

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](#).

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: 21 March 2019 End date: 22 March 2019

Proposed changes to current services (if any):

Total beds occupied across all premises included in the audit on the first day of the audit: 37

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

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 48 residents including 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 37 residents.

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 residents and staff files, observations and interviews with residents, relatives, staff and management.

The service is managed by a manager who has both management and aged care experience. The manager is supported by an experienced clinical nurse manager. They are supported by the general manager for the Archer Group. Residents, relatives and the GP interviewed spoke positively about the service provided.

The service has exceeded the standard around infection control surveillance and chaplaincy services.

This audit has identified areas for improvement around; enduring power of attorney and neurological observations following falls.

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.
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Policies and procedures adhere with the requirements of the Code of Health and Disability Services Consumers' Rights (the Code). Residents and families are informed regarding the Code and staff receive ongoing training about the Code.

The personal privacy and values of residents are respected. There is an established Māori health plan in place. Individual care plans reference the cultural needs of residents. Discussions with residents and relatives confirmed that residents and their families are involved in care decisions. Regular contact is maintained with families, including if a resident is involved in an incident or has a change in their current health. Families and friends are able to visit residents at times that meet their needs. Examples of good practice were provided.

There is an established system for the management of complaints, which meets guidelines established by the Health and Disability Commissioner.

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. The village/quality manager is responsible for the day-to-day operations. Goals are documented for the service with evidence of regular reviews. A quality and risk management

programme is in place. Data is collected, analysed and discussed and changes made as a result of trend analysis. Quality improvement plans are developed when service shortfalls are identified.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. Ongoing education and training is in place, which includes in-service education and competency assessments.

Registered nursing cover is provided each day, seven days a week. Residents and families reported that staffing levels are adequate to meet the needs of the residents.

The integrated residents' files are appropriate to the service type.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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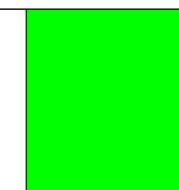
There is an admission package available prior to or on entry to the service. Registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family input. Care plans viewed demonstrate service integration and are reviewed at least six monthly. Resident files include medical notes by the contracted general practitioners and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and healthcare assistants are responsible for the administration of medicines. Medication charts are reviewed three monthly by the GP.

The diversional therapist implements the activity programme to meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings, and celebrations.

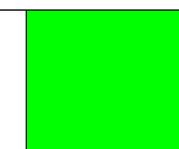
All meals are cooked on site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated. Residents commented positively on the meals and baking provided. Snacks are available at all times.

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.
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Chemicals are stored safely throughout the facility. Appropriate policies and product safety charts are available. The building holds a current warrant of fitness. All residents have a single room. There are sufficient communal showers/toilets for all other rooms. External areas are safe and well maintained with shade and seating available. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are monitored through the internal auditing system. Systems and supplies are in place for essential, emergency and security services.

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.
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Staff regularly receive education and training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enabler. No residents were using restraints and no residents were using enablers at the time of audit.

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.

All standards applicable to this service fully attained with some standards exceeded.

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 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	2	41	0	2	0	0	0
Criteria	2	89	0	2	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Families and residents are provided with information on admission, which includes information about the Code. Staff receive training around resident rights at orientation and as part of the annual training programme. Interviews with care staff; (three healthcare assistants (HCA), one registered nurse (RN), one enrolled nurse (EN), the cook, an educator and the diversional therapist (DT) confirmed their understanding of the Code. Five residents and four relatives (three rest home level and one dementia level) interviewed, confirmed that staff respect privacy and support residents in making choices.
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	PA Low	The service has in place a policy for informed consent. Completed resuscitation consent forms were evident on all resident files reviewed (five rest home and two dementia). General consent forms were evident on files reviewed. Discussions with staff confirmed that they are familiar with the requirements to obtain informed consent for entering rooms and personal care. EPOA's were not evident in the two files reviewed from the dementia unit.

informed consent.		
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Residents interviewed confirmed they are aware of their right to access independent advocacy services. Discussions with relatives confirmed that the service provides opportunities for the family/EPOA to be involved in decisions. The chaplain is identified by staff and residents as an advocate. The resident files include information on residents' family/whānau and chosen social networks.
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 and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. The activities programme includes opportunities to attend events outside of the facility. Residents are supported and encouraged to remain involved in the community. Relatives and friends are encouraged to be involved with the service and care.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	There is a comprehensive complaints policy and process implemented. Complaints forms are available. Information about complaints is provided on admission. Interviews with residents and relatives confirmed their understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints. An electronic complaint register includes written and verbal complaints, dates and actions taken. A total of six complaints were logged onto the system with no complaints logged since August last year. The service noted a trend around staff complaining about staff. A quality improvement plan has been developed and implemented, and is currently being evaluated. Meetings document that staff behaviour and the development of a caring culture towards each other is discussed. Meeting minutes from 2018 also document discussion regarding resident and relative complaints. Complaints are being managed in a timely manner, meeting requirements determined by the Health and Disability Commissioner (HDC).
Standard 1.1.2: Consumer Rights	FA	There is an information pack given to prospective residents and families that includes information about the Code and the Nationwide Advocacy Service. There is the opportunity to discuss aspects of the Code during the admission process. Residents and relatives interviewed confirmed that information had been provided to them

<p>During Service Delivery</p> <p>Consumers are informed of their rights.</p>		<p>around the Code. A manager discusses the information pack with residents/relatives on admission. Families and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>A tour of the facility confirmed there are areas that support personal privacy for residents. Staff were observed to be respectful of residents' privacy by knocking on doors prior to entering resident rooms. Residents and relatives interviewed confirmed that staff demonstrate sensitivity in regard to resident privacy and dignity and where possible, encourage the resident to be involved in their care according to their ability.</p> <p>Resident preferences are identified during the admission and care planning process and this includes family involvement. Interviews with residents confirmed their values and beliefs were considered. Interviews with healthcare assistants described how choice is incorporated into resident care.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>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.</p>	<p>FA</p>	<p>There is a Māori health plan and an individual values plan which includes cultural care and support. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. Links are established with disability and other community representative groups as requested by the resident/family. Cultural needs are addressed in the care plan. There were no residents who identified as Māori at the time of audit.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and</p>	<p>CI</p>	<p>An initial care planning meeting is carried out and the resident and/or whānau as appropriate are invited to be involved. Individual beliefs or values are discussed and incorporated into the care plan. Six-monthly multidisciplinary team meetings occur to assess if needs are being met. Family are invited to attend. Discussions with relatives confirmed that residents' values and beliefs are considered. Residents interviewed confirmed that staff take into account their values and beliefs. Chaplaincy services have improved services and support to residents.</p>

respect their ethnic, cultural, spiritual values, and beliefs.		
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>The facility has a staff Code of Conduct which states there will be zero tolerance against any discrimination occurring. Staff are supervised to ensure professional practice is maintained in the service. Staff job descriptions include responsibilities. Interviews with the managers and care staff confirmed their awareness of professional boundaries. Healthcare assistants from the dementia unit described how they build a supportive relationship with each resident. Interviews with a family member from the dementia unit confirmed the staff maintain a calm and supportive environment. The training schedule included training around abuse and neglect, communication and dignity.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service receives support from the district health board, which includes nurse specialist's visits. Physiotherapy services are provided on-site once a week and a physiotherapy assistant works four hours a week. A podiatrist is on-site every six weeks. There is a regular in-service education and training programme for staff. The service has links with the local community and encourages residents to remain independent.</p> <p>Evidence-based practice is evident, promoting and encouraging good practice. Registered nursing staff are available seven days a week, 24 hours a day. House GPs visit the facility once a week and provide an after-hours service. The general practitioner (GP) reviews residents identified as stable every three months, with more frequent visits for those residents whose condition is not deemed stable. The GP interviewed was satisfied with the level of care that is being provided.</p> <p>The service has a high emphasis on training and employs a designated trainer. This has resulted in a range of training to suit different learning styles, such as online, assessments/competencies, training packages and a complete review of the orientation programme. Staff interviewed, stated that they feel very well supported through training.</p> <p>Quality data is benchmarked through an outside agency.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment</p>	FA	<p>There is an accident/incident reporting policy to guide staff in their responsibility around open disclosure. Staff are required to record family notification when entering an incident into the system. All 10 incident reports reviewed for February 2019 met this requirement. Family members interviewed confirmed they are notified following a change of health status of their family member. There is an interpreter policy in place and contact details of interpreters were available.</p>

conducive to effective communication.		
<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>	FA	<p>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 37 residents including 10 residents in the dementia unit (named memory support unit) and 27 rest home residents including; one respite resident and one funded through the long-term support - chronic health conditions (LTS-CHC) who was also under 65 years old. There were no rest home level funded residents in the license to occupy serviced apartments.</p> <p>Thorrington Village has a strategic plan and business 2019 to 2020. The plan reflects the special character of faith-based care and to create a culture of respect and treating others well. A quality plan and annual goals are documented and reviewed through the quality process. Data such and incidents and accidents and Internal audits are discussed at meetings and reported monthly to the board and general manager.</p> <p>Thorrington Village is managed by an experienced village/quality manager who has been in the role since 2015. He is supported by a clinical nurse manager/registered nurse (RN), who has been in the role for two years. They are supported by the general manager for the Archer Group.</p> <p>The village manager and clinical nurse manager have maintained at least eight hours of professional development activities related to managing an aged care facility.</p>
<p>Standard 1.2.2: Service Management</p> <p>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.</p>	FA	<p>The clinical manager, supported by the general manager cover during the temporary absence of the village manager.</p>
<p>Standard 1.2.3: Quality And Risk Management</p>	FA	<p>An established quality and risk management system is embedded into practice. Quality and risk performance is reported across facility meetings and to the general manager and board.</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>Resident meetings are monthly. Minutes are maintained. An annual resident and relative survey was in the process of being undertaken at the time of audit.</p> <p>The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. The service's policies are reviewed by an external consultant who provides the policies, procedures and the quality programme for the service. Clinical guidelines are in place to assist care staff.</p> <p>The quality monitoring programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility. There are clear guidelines and templates for reporting. The facility has implemented established processes to collect, analyse and evaluate data. This is utilised for service improvements; action plans are developed when service shortfalls are identified, and these are monitored by group office. Results are communicated to staff at the monthly staff/quality/risk meetings and reflect actions being implemented and signed off when completed. Communication to staff is enhanced by daily briefings as well as handovers.</p> <p>Health and safety policies are implemented and monitored through the quality/risk meetings, weekly clinical meetings, management meetings and through board meetings. Risk management, hazard control and emergency policies and procedures are in place. A health and safety representative was interviewed about the health and safety programme. There are procedures to guide staff in managing clinical and non-clinical emergencies. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made.</p> <p>Falls prevention strategies are in place including (but not limited to): individual and group exercise programme; meeting individual toileting needs; sensor mats; increased monitoring; identification and meeting of individual needs.</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>There is an incident/accident reporting policy that includes definitions and outlines responsibilities including: immediate action, reporting, monitoring, corrective action to minimise and debriefing. Individual incident/accident reports are completed on the electronic system for each incident/accident with immediate action noted and any follow-up action required.</p> <p>A review of ten incident/accident forms identified that forms are fully completed and include follow-up by a registered nurse. However, neurological observations were not evidenced to be consistently completed for unwitnessed falls as per policy (link 1.3.6.1).</p> <p>The clinical nurse manager and village manager were able to identify situations that would be reported to statutory authorities. No notifications have been sent since the previous audit.</p>

family/whānau of choice in an open manner.		
<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>There are human resources policies in place. Eight staff files reviewed (the village/quality manager, the clinical nurse manager, one registered nurse, the cook the diversional therapist and three healthcare assistants) included a recruitment process including: reference checking, signed employment contracts and job descriptions, completed orientation programmes and annual performance appraisals.</p> <p>A register of registered nursing staff and other health practitioner practising certificates is maintained.</p> <p>The orientation programme provides new staff with relevant information for safe work practice. There is an implemented annual education and training plan that exceeds eight hours annually. The training plan is implemented using a variety of methods including 'train the trainer' model, on-line learning and traditional training. Staff are paid to attend training. Incidental training is provided according to identified need and at staff request. There is an attendance register for each training session and an individual staff member record of training.</p> <p>There are twenty staff including the DT who regularly works in the dementia unit. Eighteen staff have completed the required NZQA dementia education modules and two staff who have been employed in the last three months, are enrolled on the Careerforce programme including the second DT.</p> <p>Registered nurses are supported to maintain their professional competency. Two of two permanent registered nurses have completed their interRAI training. There are implemented competencies for registered nurses.</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>A policy is in place for determining staffing levels and skills mix for safe service delivery. The service has a clinical nurse manager and a village manager Monday to Friday and on call. There is a second RN on five days a week with an additional EN on four days a week.</p> <p>The dementia unit staffing for ten residents;</p> <p>An RN or EN visits each day as well as the clinical nurse manager. Staff reported that they feel supported by the management team.</p> <p>There is one healthcare assistant on long and one on a short shift for the AM and the PM shifts and one healthcare assistant on nights.</p> <p>The rest home is divided into two wings, jointly the two wings have the following staffing for 27 residents; two healthcare assistants in the AM plus the healthcare assistant from the serviced apartments available to assist. The PM staffing includes two healthcare assistants on long shift and one healthcare assistant on short shift. The night has two healthcare assistants.</p> <p>Staff were visible and were attending to call bells in a timely manner as confirmed by all residents interviewed.</p>

		Residents and family members interviewed reported there are sufficient staff numbers.
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>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. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access. Entries are legible, dated and signed by the relevant caregiver or nurse including designation. Individual resident files demonstrate service integration.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>There are policies and procedures to safely guide service provision and entry to services including an admission policy. The service has an information pack available for residents/families at entry, there is dementia specific information available. The admission agreements reviewed meet the requirements of the ARCC contract. Exclusions from the service are included in the admission agreement. All seven admission agreements sighted were signed and dated. Not all residents in the dementia unit had an EPOA on file (link 1.1.10.4).</p> <p>Admission policies and processes are documented. Prior to entry all potential residents have a needs assessment completed by the needs assessment and coordination service to assess suitability for entry to the service. Residents receive an information pack outlining the services able to be provided, the admission process and entry to the service.</p> <p>Residents and relatives interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the care home manager or clinical manager.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Policy describes guidelines for death, discharge, transfer, documentation and follow-up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities and communication with family is made.</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>	<p>FA</p>	<p>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were two residents self-administering on the day of audit. There are no standing orders in use. There are no vaccines stored on site.</p> <p>The facility uses an electronic and blister pack system. Medications are checked on arrival and any pharmacy errors are recorded and fed back to the supplying pharmacy. Medications are administered by the RN or senior medication competent HCAs. Medication education has been completed in the last year. The medication fridge temperature is checked daily. All eye drops are dated once opened.</p> <p>Staff sign for the administration of medications electronically. Fourteen medication charts were reviewed (including one respite and long-term chronic care). Medications are reviewed at least three monthly by the GP. There was photo identification and allergy status recorded. 'As required' medications had indications for use charted.</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 service delivery.</p>	<p>FA</p>	<p>The service has one hospitality supervisor who works 0730-1600 Tuesday to Saturday and another cook who works the same hours Sunday to Monday. There is one kitchenhand in the morning and two in the afternoon. All have current food safety certificates. The hospitality supervisor oversees the procurement of the food and management of the kitchen. There is a well-equipped kitchen and all meals are cooked on site. Meals are served directly from the kitchen to the dining rooms. As the dining rooms are small there are two sittings. Meals going to rooms on trays have covers to keep the food warm. Special equipment such as lipped plates is available. On the day of audit, meals were observed to be hot and well-presented and residents stated that they were enjoying their meal. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures were monitored and recorded daily. Food temperatures are checked, and these were all within safe limits. The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. This is reviewed six monthly as part of the care plan review. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes were noted on a whiteboard. The four-weekly menu cycle is approved by a dietitian. Snacks are available at all times. All residents and family members interviewed were satisfied with the meals.</p> <p>The food control plan was approved on the 23 August 2018.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to</p>	<p>FA</p>	<p>The service records the reason for declining service entry to residents should this occur and communicates this to residents/family. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency.</p> <p>The service records the reasons for declining service entry to residents should this occur and communicates this</p>

the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.		to residents/family/whānau. Anyone declined entry is referred to the needs assessment service or referring agency for appropriate placement and advice.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. InterRAI assessments had been completed for all six long-term residents whose files were sampled. Other assessments tools in use were falls risk, pressure injury risk, continence and nutrition. Care plans sampled were developed on the basis of these assessments.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. All care plans are resident-centred. Interventions documented support needs and provide detail to guide care. Short-term care plans are in use for changes in health status. Residents and relatives interviewed stated that they were involved in the care planning process. There was evidence of service integration with documented input from a range of specialist care professionals including the podiatrist, wound care specialist (one chronic wound) and mental health care team for older people. The care staff interviewed advised that the care plans were easy to follow, and guidelines were clear. The respite resident had a short stay care plan in place.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Low	When a resident's condition changes the registered nurse initiates a GP consultation. Staff stated that they notify family members about any changes in their relative's health status. All care plans sampled had interventions documented to meet the needs of the resident. Care plans have been updated as residents' needs changed. Resident falls are reported on accident forms and written in the progress notes. Neurological observations were not always consistently completed for unwitnessed falls or falls where residents hit their heads. Care staff interviewed stated there are adequate clinical supplies and equipment provided including continence and wound care supplies. Wound assessment, wound management and evaluation forms are in place for all wounds. Wound monitoring occurs as planned. There are currently four wounds being treated. One chronic wound (non-facility acquired) has had input from the GP and wound care specialist. The resident attends a hospital clinic two weekly for a vac

		<p>dressing. There are no pressure injuries.</p> <p>Monitoring forms are in use as applicable such as weight, vital signs and wounds. Behaviour charts are available for any residents that exhibit challenging behaviours.</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 setting of the service.</p>	FA	<p>There is a diversional therapist who oversees the activities programme for the Archer sites. The facility also has a diversional therapist and a social coordinator. Both work sixteen hours a week Monday to Friday. There is also a pool of volunteers. On the day of audit residents were observed taking part in a church service, participating in exercises, going on a van outing and enjoying interacting with visiting schoolchildren.</p> <p>There is a weekly programme in large print on noticeboards in the lounges and hallways. Residents have the choice of a variety of activities in which to participate, and every effort is made to ensure activities are meaningful and tailored to residents' needs. These include exercises, games, quizzes, movies, crafts and walks outside. Happy hour is every Friday.</p> <p>Those residents who prefer to stay in their room or who need individual attention have one-on-one visits to check if there is anything they need and to have a chat. Most residents were out of their rooms.</p> <p>There is a weekly church service. The facility has a chaplain who works 20 hours a week. Catholics have a lay volunteer who comes in to give communion (link 1.1.6).</p> <p>There are twice weekly van outings. There are regular entertainers visiting the facility. Special events like birthdays, Easter, Mothers' Day, Anzac Day, St Patricks Day and Valentine's Day are celebrated.</p> <p>Staff and family dogs visit regularly. One rest home resident has a cat and there is a cat in the memory support unit.</p> <p>There is community input from pre-schools, schools, and a monthly library visit. One resident goes out weekly to a friendship group. The facility also visits other Archer facilities for bowls tournaments.</p> <p>Residents have an activity assessment completed over the first few weeks following admission that describes the residents past hobbies and present interests, career and family. Resident files reviewed identified that the activity plan is based on this assessment. Activity plans are evaluated at least six monthly and the diversional therapist is currently liaising with the RNs so that this is at the same time as the review of the long-term care plan. Resident meetings are held bi-monthly.</p>
<p>Standard 1.3.8: Evaluation Consumers' service</p>	FA	<p>The six long-term care plans reviewed had been evaluated by the registered nurse six monthly or when changes to care occurs. Short-term care plans for short-term needs are evaluated and signed off as resolved or added to the long-term care plan as an ongoing problem. Activities plans are in place for each of the residents and these</p>

<p>delivery plans are evaluated in a comprehensive and timely manner.</p>		<p>are also evaluated six monthly. The multidisciplinary review involves the RN, GP and resident/family if they wish to attend. There are three monthly reviews by the GP for all residents. The family members interviewed confirmed that they are informed of any changes to the care plan.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where residents had been referred to the wound care nurse specialist and mental health services for older people. Discussion with the registered nurse identified that the service has access to a wide range of support either through the GP, specialists and allied health.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>There are policies regarding chemical safety and waste disposal. All chemicals were clearly labelled with manufacturer's labels and stored in locked areas. Safety datasheets and product sheets are available. One sharps container is available and meets the hazardous substances regulations for containers. The hazard register identifies hazardous substances and staff indicated a clear understanding of processes and protocols. Gloves, aprons, and goggles are available for staff. A spills kit is available.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an</p>	<p>FA</p>	<p>The building holds a current warrant of fitness which expires 1 July 2019. There is a property manager who manages all Archer sites. There is a maintenance person on site for 20 hours a week. Contractors are used when required.</p> <p>Electrical equipment has been tested and tagged. The scales are checked annually. Hot water temperatures</p>

<p>appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		<p>have been monitored randomly in resident areas and were within the acceptable range. The communal lounges, hallways and bedrooms are carpeted in both the rest home and memory support unit. The utility areas such as the kitchen and laundry have vinyl flooring. Communal showers and all toilets have nonslip vinyl flooring. All corridors have safety rails and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens were well maintained. There is currently scaffolding in some garden areas (due to painting the exterior of the facility including the roof) but all these areas are safely fenced and signposted. All outdoor areas have seating and shade. There is safe access to all communal areas.</p> <p>There dementia unit is designed so that space and seating arrangements provide for individual and group activities. There are quiet, low stimulus areas and seating alcoves that provide privacy when required. There is a safe and secure outside walking and garden area, which is easy for dementia residents to access.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>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.</p>	<p>FA</p>	<p>All rooms are single. 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. Fixtures, fittings and flooring are appropriate. Toilet/shower facilities are easy to clean. There is ample space in toilet and shower areas to accommodate shower chairs if required. There are privacy signs on all shower/toilet doors.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and</p>	<p>FA</p>	<p>There are 30 single rooms. There is sufficient space to allow care to be provided and for the safe use of mobility equipment. Staff interviewed reported that they have more than adequate space to provide care to residents. Residents are encouraged to personalise their bedrooms as viewed on the day of audit.</p>

setting.		
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>There are large and small communal areas. Activities occur in the larger areas and the smaller areas are spaces where residents who prefer quieter activities or visitors may sit. The dining rooms in each area are small so there are two sittings at each meal.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>All laundry is done on site by a laundry worker who works 0730-1600 Monday to Friday and one who works the same hours Saturday and Sunday. The laundry is divided into a 'dirty' and 'clean' area. There is a laundry and cleaning manual. Cleaning and laundry services are monitored through the internal auditing system. The cleaners' equipment was attended at all times or locked away. All cleaning chemicals were labelled. There is no sluice room. Disposal of soiled water and the sluicing of soiled linen are completed in the 'dirty' area of the laundry if required. The laundry is kept locked when not in use.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>The documented emergency/civil defence management plan complies with all applicable statutory requirements. It continues to be reviewed and improved as necessary.</p> <p>The service has an approved evacuation plan. The last fire evacuation drill was held March 2019. The trial evacuation report letter was sighted. Staff attendance is recorded in the training records.</p> <p>Civil defence equipment and resources are available, and this was discussed with the village manager. 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/civil defence emergency. A gas barbeque is also available.</p> <p>Staff are responsible for checking the facility for security purposes on the afternoon and night shifts. The memory support unit is keypad accessed by staff and family. External lighting and security systems are adequate for</p>

		<p>safety and security.</p> <p>The nurse call system is appropriate for the size of the facility and call bells are accessible in rooms, communal showers and toilets.</p> <p>There is a minimum of one person who is available 24 hours a day, seven days a week with a current first aid/CPR certificate. The person who drives the van also has a current first aid certificate.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All bedrooms and communal areas have ample natural light and ventilation. All heating is electrical. They are currently introducing heat pumps. Staff and residents interviewed stated that this is effective. There is an outdoor area where residents smoke. All other areas are smoke free.</p>
<p>Standard 3.1: Infection control management</p> <p>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.</p>	FA	<p>Thorrington Village has a fully implemented infection control programme in place. 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 incident reporting system and benchmarked with other similar facilities. The clinical nurse manager is the designated infection control nurse and has access to the DHB infection control nurse and microbiologist. Audits have been conducted and include hand hygiene, infection control practices in the laundry and cleaning service. Education is provided for all new staff on orientation. Staff interviewed stated they had adequate supplies of personal protective equipment (PPE). The infection control programme is reviewed annually by the external consultant.</p>
<p>Standard 3.2: Implementing the infection control programme</p>	FA	<p>The clinical nurse manager is the infection control nurse and is aware of the need to analyse data and the reasons behind this. The infection control data is entered into the electronic system and reviewed monthly by the service.</p> <p>There are adequate resources to implement the infection control programme for the size and complexity of the</p>

<p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>		<p>organisation. The IC nurse has good external support from the local laboratory infection control team and IC nurse specialist at the DHB. The infection control team is representative of the facility. Infection prevention and control is included as part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.</p>
<p>Standard 3.3: Policies and procedures</p> <p>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.</p>	<p>FA</p>	<p>The infection control policies and procedures are appropriate for the size and complexity of the service. The 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 were developed by an external consultant and have been reviewed and updated.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>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. The infection control nurse has completed 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.</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>	<p>CI</p>	<p>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. Surveillance of all infections is entered on to a monthly infection summary. This data is monitored and evaluated monthly and annually. Infections are part of the key performance indicators. Outcomes and actions are discussed at quality/staff meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Restraint practices are only used where it is clinically indicated and justified, and other de-escalation strategies have been ineffective. Restraint minimisation policies and procedures are comprehensive and include definitions, processes and use of restraints and enablers.</p> <p>There were no residents using enablers and no residents with restraints during the audit.</p> <p>Staff training is in place around restraint minimisation and enablers, falls prevention and management of challenging behaviours.</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 1.1.10.4</p> <p>The service is able to demonstrate that written consent is obtained where required.</p>	PA Low	All resident files reviewed included a NASC assessment and approval for the level of care including two resident files reviewed in the dementia unit. EPOA's were not evident in the two files reviewed from the dementia unit.	Two of two resident files reviewed in the memory support unit (dementia unit) did not have enduring powers of attorney	<p>Ensure enduring powers of attorney are obtained and activated for residents in the dementia unit</p> <p>180 days</p>
<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,</p>	PA Low	The HCAs and RNs could describe the incident and accident process and they ensure all incidents are reported. Progress notes and incident forms document RN follow-up post falls; however, neurological observations were not always documented according to timeframes.	Of four falls related incident forms where the resident had recorded a blow to the head; three did not document the neurological observation according to the set timeframes in the policy.	Ensure that neurological observations are documented according to policy.

and desired outcomes.				90 days
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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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.1.6.2</p> <p>The consumer and when appropriate and requested by the consumer the family/whānau of choice or other representatives, are consulted on their individual values and beliefs.</p>	CI	<p>Archer Care, Thorrington Village was founded with a Christian belief and set of values, and welcomes everyone from all walks of life. The chaplains have an embedded continued improvement process of offering pastoral care to the residents and their family who requests this.</p>	<p>Thorrington Village, as part of their faith-based culture aim to provide support and pastoral care to all the residents and family members who reside in the home. Chaplaincy services are rostered for 20 hours a week and provide on call services. On the day of audit, the chaplaincy service was providing additional support in the wake of recent Christchurch events, this included a special service and one-on-one support to some residents who required additional assistance.</p> <p>The regular services and one-on-one counselling have been welcomed by residents and their families, and this was evidenced through meeting minutes and also a range of ‘thank you cards’.</p>
<p>Criterion 3.5.7</p> <p>Results of surveillance, conclusions, and specific</p>	CI	<p>Individual infection reports are completed, and any trends identified are discussed at the</p>	<p>The service benchmarks infections and compared against an industry norm. The service noted that urinary tract infections had been above the higher limit for November. An action plan was</p>

<p>recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.</p>		<p>clinical and infection control meetings. Infection control results and data are reviewed, and a quality improvement plan is developed for any trends identified and communicated to staff.</p>	<p>documented. This is included an emphasis on education for staff and also for residents. Additional fluid rounds were commenced. The UTIs have reduced since November with a continued downward trend and have remained less than the industry norm since, with only two (per occupied bed day) for February 2019.</p>
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End of the report.