# Thorrington Village Limited - Thorrington Village

## Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](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: 2 December 2020 End date: 3 December 2020

**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:** 44

# 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** |
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|  | 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 governed by a charitable trust and is part of the Archer Retirement Village. The service is certified to provide rest home and dementia level care for up to 58 residents. On the day of audit there were 44 residents.

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

The village manager (non-clinical) has been in his role for five and a half years, he is supported by a clinical manager who has been in the role for four years and has experience in age care. They are supported by a general manager, who oversees operations across three sites.

Residents, relatives and the GP interviewed were very complimentary of the services and care they receive.

The service has addressed one of the two previous shortfalls around enduring powers of attorney. An improvement continues to be required around monitoring residents.

This surveillance audit identified areas for improvement around timeframes and controlled drug checks.

## Consumer rights

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| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | Standards applicable to this service fully attained. |

A policy on open disclosure is in place. There is evidence that residents and relatives are kept informed. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service. A system for managing complaints is in place.

## Organisational management

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| 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. |

The site manager and clinical manager are 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 documented electronically. The risk management programme includes managing adverse events and health and safety processes.

Residents receive appropriate services from suitably qualified staff. Human resources are managed. An orientation programme is in place for new staff. Ongoing education and training has been implemented, which includes in-service education and competency assessments. Residents, relatives and staff report that staffing levels are adequate to meet the needs of the residents.

## Continuum of service delivery

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| 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. |

The registered nurses are responsible for each stage of service provision. The registered nurses assess, plan and review residents' needs, outcomes and goals with the resident and/or family/whānau input. Care plans viewed on the electronic system demonstrated service integration. The general practitioner reviews the residents at least three-monthly. Allied health professionals are involved in the care of residents as required.

Medication policies reflective of legislative requirements and guidelines were documented. The registered nurses and senior healthcare assistants are responsible for administration of medicines and complete annual education and medication competencies. The electronic medicine charts reviewed met legislative prescribing requirements and were reviewed at least three-monthly by the general practitioner.

The social events team provide and implement an interesting and varied activity programme. The programme includes community visitors and outings, entertainment and activities that meet the individual recreational, physical, cultural and cognitive abilities and preferences for each resident group.

Residents' food preferences and dietary requirements are identified at admission and all meals are cooked on-site. 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

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| 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. |

Thorrington Village has a current building warrant of fitness and reactive and preventative maintenance occurs. All equipment is tagged and tested annually. There is easy access to all internal and external communal areas with seating and shade provided in the garden areas. The dementia areas are secure.

## 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. |

Thorrington Village has restraint minimisation and safe practice policies and procedures in place. At the time of the audit there were no residents using restraint or enablers. Staff receive training in restraint minimisation and challenging behaviour management.

## Infection prevention and control

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| 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. |

Thorrington Village continues to implement their infection surveillance programme. Infection control issues are discussed at both in the infection control and quality/staff meetings. The infection control programme is linked with the quality programme.

Covid19 was well documented, logs were maintained and contact tracing methods continue in line with current guidelines. There were adequate supplies of personal protective equipment sighted. There have been two outbreaks since the previous audit which were well managed.

## Summary of attainment

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

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| **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 | 13 | 0 | 2 | 1 | 0 | 0 |
| **Criteria** | 0 | 38 | 0 | 2 | 1 | 0 | 0 |

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| **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).

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| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | Complaints forms are available at the entrance to the facility. Information around the complaints process is provided on admission. A record of all complaints, both verbal and written is maintained by the site manager on the complaints register. There have been no complaints made by residents or relatives since the previous audit. A record of staff complaints has been maintained, investigated and resolved. Documentation and correspondence reflected evidence of responding to the complaints in a timely manner with appropriate follow-up actions taken. Healthcare assistants interviewed confirmed that complaints and any required follow-up is discussed at staff meetings as sighted in the minutes. Complaint documentation requiring changes to care planning are signed by staff once read. Residents and relatives advised that they are aware of the complaints procedure and how to access forms, and feel comfortable discussing any concerns with the management team. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Comprehensive information is provided at entry to residents and family/whānau. Two residents and three relatives (including two from the dementia unit) interviewed stated that they were welcomed on entry and were given time and explanation about the services and procedures. Both the site manager and clinical manager were available to residents and relatives and they promote an open-door policy. Incident forms reviewed in November 2020 evidenced that relatives had been notified on all occasions. The relatives interviewed advised that they are notified of incidents and when residents’ health status changes promptly. The registered nurse, three healthcare assistants, the social event manager for both facilities and the social event coordinator interviewed fluently describe instances where relatives would be notified. |
| 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 part of the Archer Group and is governed by a charitable trust board. The Archer Group own three retirement villages, two (Thorrington Village and Archer Village) have care centres.  Thorrington village care centre provides rest home and dementia level care to up to 58 residents. There are five certified double rooms (all single occupancy) and five single certified rooms in the memory support (dementia unit). There are 13 certified serviced apartments for residents receiving rest home level care.  On the day of audit there were 44 residents: 34 rest home including seven residents at rest home level care in the serviced apartments, and 10 dementia level residents. Forty-three residents were under the age-related residential care contract, and there was one resident on a long-term support- chronic health contract (LTS-CHC).  The general manager oversees the three sites, and reports to the board monthly. The village (site) manager is non-clinical and has been in his role for five and a half years. The site manager reports to the general manager on a variety of operational issues and reports to the leadership, quality and risk meeting held monthly. The clinical manager (registered nurse) has been in her role for four years, and has previous hospital and age care experience. They are supported by registered nurses and long-standing healthcare assistants.  The service has a current strategic plan, a business plan and a quality and risk management programme. The service mission reflects the Christian values. There are 2020-2021 goals for all departments. Progress toward previous goals has been monitored and documented at the leadership, quality and risk meetings.  The village manager has completed the eight hours education in relation to managing an age care facility. |
| 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 | Thorrington Village is implementing a quality and risk management system. There are policies and procedures being implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. These are checked by an aged care consultant, who reviews policies to ensure they align with current good practice and meet legislative requirements.  Monthly accident/incident reports, infections and results of internal audits are completed. Quality matters are taken to the monthly quality meetings which includes health and safety and infection control. Clinical (staff) meetings occur bi-monthly, any topical matters are discussed at handover at the time, and reviewed at the meeting. Resident meetings occur monthly.  An internal audit programme is in place that includes aspects of clinical care. Issues arising from internal audits are either resolved at the time or developed into a corrective action plan. The closure of corrective actions resulting from internal audit programme was recorded, signed off by the site manager. Quality/staff and resident meeting minutes include an accurate reflection of the discussion/outcomes of the meetings, including follow up to actions taken as matters arising. Record of monthly risk identification, and quality indicators is maintained and discussed at the monthly meetings and a copy is filed with the completed monthly internal audits.  Annual satisfaction surveys occur. The food services survey indicated overall satisfaction, and provided feedback and suggestions. The resident survey evidenced overall satisfaction with eight of nine respondents’ responses ‘strongly agree’ for GP services, recognising and acting on changes in health, and being welcoming. High satisfaction was noted around the environment and staff appearance. Five respondents were very satisfied with food services and activities showed overall satisfaction. The relative satisfaction survey evidenced overall satisfaction with high points around food services and activities.  Falls management strategies include the use of sensor mats, and the development of specific falls management plans to meet the needs of each resident who is at risk of falling. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | Discussions with both the site manager and clinical manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been no notifications required since the previous audit.  The service collects incident and accident data and reports aggregated figures monthly to the quality meeting. Electronic incident forms are completed by staff, the resident is reviewed by the RN at the time of event and the form is forwarded to the clinical manager for final sign off. Ten incident forms reviewed identified registered nurse follow up. There is an incident reporting policy to guide staff in their responsibility around open disclosure. Incident/accident forms include a section to record relatives have been notified. Minutes of the combined quality/staff meetings reflect a discussion of incident stats and analysis. The healthcare assistants interviewed could discuss the incident reporting. There have been two outbreaks since the previous audit, (respiratory in 2019 and gastro in 2020) which were reported to the public health team, logs were maintained. Both outbreaks were managed well. |
| 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 is a total of 50 staff across the facility. There are human resources policies to support recruitment practices. A list of practising certificates is maintained. Five staff files were reviewed (one registered nurse, one social event coordinator and three healthcare assistants). All had relevant documentation relating to employment, however not all staff had 2020 appraisals due to Covid. The service is working towards this.  The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme includes documented competencies and induction checklists (sighted in files). Staff interviewed were able to describe the orientation process and believed new staff were adequately orientated to the service.  There is an education plan that is being implemented that covers all contractual education topics and exceeds eight hours annually. There is evidence in the registered nurse files of attendance at the DHB external training. Interviews with healthcare assistants confirm participation in the New Zealand Qualification Authority (NZQA) through the Careerforce training programme. Currently there are 14 healthcare assistants who have completed the dementia standards, (11 of 13 currently working in the unit have completed the dementia standards). There are three healthcare assistants with level 4 NZQA, and 12 with level 3 NZQA. A further three healthcare assistants are enrolled to complete level 3 training.  A competency programme is in place that includes annual medication competency for staff administering medications. Core competencies are completed, and a record of completion is maintained and signed. Competency questionnaires were sighted in reviewed files. The clinical manager and the registered nurse are interRAI trained. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is a total of 50 staff. The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. The general manager (non clinical is available Monday to Friday between all sites). The site manager, and clinical manager are full-time Monday to Friday. The clinical manager is on call after hours. The registered nurse works Monday to Friday from 7.30am to 4pm.  Residents, and relatives interviewed stated there were sufficient numbers of staff on duty to safely deliver residents cares. Staff interviewed felt there was sufficient staff on duty.  The Larch memory support (dementia) unit has 10 residents.  The morning shift has two healthcare assistants; 1x 7.30am to 4pm (medication competent) and 1x 8am to 1pm. The afternoon shift has two healthcare assistants; 1x 4pm to midnight (medication competent) and 1x 4pm to 7pm. Nightshift is covered by one healthcare assistant from midnight to 8am.  Maples unit has 13 rest home residents;  The morning shift has one healthcare assistant on each shift from 7.30am to 4pm, 4pm to midnight and midnight to 8am.  The Kowhai unit has 14 rest home residents. There is one healthcare assistant on each shift from 7.30am to 4pm, 4pm to midnight and midnight to 8am. The healthcare assistant who finishes in the Larch unit at 7pm goes to the rest home areas and is shared between the rest home areas and the serviced apartments from 7pm to 9pm.  The Cedar serviced apartment unit has seven residents receiving rest home level care. There is one healthcare assistant on the morning shift from 7.30am to 1pm. The afternoon and night shift are covered by the rest home staff.  The healthcare assistants who administer medications all had current competencies in place. There is at least one member of staff on duty at all times with a current first aid certificate.  Residents, and relatives interviewed stated there were sufficient numbers of staff on duty to safely deliver residents cares. Staff interviewed felt there was sufficient staff on duty. |
| 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. | PA Low | The service has implemented an electronic medication system. Medications are managed appropriately. Ten medication charts were reviewed. All regular and as required medications are packed in blister packs in four weekly cycles. The three medication trolleys are locked in the medication room with keypad access. Controlled drugs are appropriately stored, however not all checks were consistently completed. There are no expired medications, eye drops, and creams are dated on opening. Medication fridge and room temperatures were recorded and remain within expected ranges.  Medication charts sampled were reviewed three-monthly by the attending GP. Resident photos and documented allergies or nil known were evident on the ten medication electronic charts reviewed. An annual medication administration competency was completed for all staff administrating medications and medication training has been conducted. There were three rest home residents’ self-medicating inhalers, creams and eye drops. Competencies were in place and had been reviewed three-monthly by the GP. |
| 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 | All meals and home baking are prepared and cooked on-site. A food control plan is in place expiring in February 2021. All containers of dry food stored in the pantry are labelled and dated. All perishable goods are date labelled. Fridge and freezer temperatures are monitored and recorded daily. End cooked temperatures are recorded using the food control plan documentation. A cleaning schedule is maintained. Staff have been trained in food safety.  There is a seasonal menu in place which had been reviewed by a dietitian. The cook is informed of resident dietary needs and changes. Likes and dislikes are accommodated. Additional or modified foods such as soft foods, pureed and vegetarian meals can be provided. Cultural needs are accommodated. Meals are well presented and freshly cooked, and residents who required assistance had support from the staff. Nutritional supplements are available for residents with unintentional weight loss. Nutritional snacks are available 24/7. The cook interviewed was aware of residents’ food preferences and residents with unintentional weight loss. Residents and relatives interviewed were complimentary about the meals provided. |
| 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 | When a resident's condition alters, a registered nurse initiates a review and if required, GP, nurse specialist consultation. The registered nurse and healthcare assistants follow the plan and report progress against the plan each shift. There is documented evidence on the family contact form in each resident file that indicates relatives were notified of any changes to their relative’s health. Discussions with relatives confirmed they are notified promptly of any changes to their relative’s health. Acute plans of care are used for short term/acute changes in care. These were in place for wounds and infections in the residents’ files reviewed.  A review of the incident reports evidenced neurological observations were completed following all un-witnessed falls. The previous shortfall has been addressed.  There was one surgical wound on the day of the audit. The wound chart was completed and had an assessment, plan and evaluation to evidence the healing of the wound. Adequate dressing supplies were sighted in treatment room.  Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified. There is access to a continence nurse specialist by referral. Residents are weighed monthly or more frequently if weight is of concern.  Monitoring forms are used for weight and vital signs, blood sugar levels, pain, food and fluid charts. However, there were no behaviour monitoring charts used in the memory loss unit for residents with challenging behaviours. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The social events team is led by an experienced full time social event manager, (qualified diversional therapist) who provides oversight of social events across all sites. She is supported by two social event coordinators at Thorrington. Both are employed for 16 hours a week. The social event coordinator interviewed is a qualified diversional therapist.  A social (activity) profile is completed on admission in consultation with the resident/family (as appropriate). The Archer group use the tree of life to provide a visual history of the resident’s life and uses a ‘simply me’ tool to identify routines and preferences. Documentation in the resident files was individualised and reflected the specific needs and interests of each resident. In the resident files reviewed, the activity care plans and evaluations were individualised and had been reviewed at least six-monthly.  A monthly planner is developed which is provided to all residents and displayed on noticeboards. The routine programme includes exercises, newspaper reading, group games, swimming at the sister facility, music, karaoke, art and craft and outings. Weekend activities are led by staff. Church services are held weekly and communion is available for residents. Resident outings include (but not limited to): trips to Lyttleton harbour, shopping malls, and picnic afternoon teas. The social events team have current first aid certificates and are accompanied by either a volunteer or an HCA. The local pre school, and schools visit the facility and perform concerts for the residents.  In the memory support unit (dementia) there are a range of activities including exercises, music, walking groups, art and crafts and physical group games. There are joint activities where the residents in the memory support unit join the rest home residents for entertainers, and large group activities.  There is evidence that the residents have input into review of the wider programme. Informal monthly wellness forums are held to reflect on the month, including suggestions to include in the programme for the following month and feedback on activities of lower satisfaction. Formal resident meetings are held monthly, which provides a more structured review of the programme and residents provide feedback of their suggestions, concerns and issues across the departments. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Initial care plans and long-term care plans were in place for residents; however, these had not always been completed within expected timeframes (link 1.3.3.3). Previous evaluations reviewed, identified if the resident goals had been met or unmet. The GP reviews the residents at least three monthly or earlier if required. Ongoing nursing evaluations occur as indicated and are documented within the electronic progress notes. Relatives are invited to attend GP reviews (documented in the progress notes), if they are unable to attend, they are updated of the changes as documented in the progress notes. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | Thorrington Village displays a current building warrant of fitness which expires on 1 July 2021. Regular and reactive maintenance occurs. Medical equipment has been calibrated. Test and tagging of electrical appliances are completed on an annual basis. Hot water temperatures are checked monthly with temperatures recorded noted to be within acceptable limits. Residents were observed to mobilise safely around the facility. There are sufficient seating areas throughout the facility. External areas are well maintained with lawn and gardens which provide seating and shade. The memory support unit is secured with keypad entry. All internal and external areas were secure and easily accessible with shaded areas in the garden for residents to enjoy. Healthcare assistants interviewed confirmed there was adequate equipment to carry out the cares according to the resident needs as identified in the care plans. Cleaning schedules were reviewed during COVID 19 and these continue to be implemented. |
| 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 monitoring is the responsibility of the IC coordinator (the clinical manager). All infections are entered into the electronic database, which generates a monthly analysis of the data. There is an end of month analysis with any trends identified and corrective actions for infection events above the industry key performance indicators. There are monthly comparisons of data. Outcomes are discussed at the leadership/quality meetings, and were documented as discussed with staff at meetings.  There was a respiratory outbreak in 2019, and a gastroenteritis outbreak in June 2020, which were managed and documented well, with notifications made in a timely manner.  Covid-19 was manage well. Logs were maintained of staff and resident screening. Staff, residents and relatives felt updated and well informed throughout lockdown levels. A resource folder was maintained with current advice and regulations. A flip chart, for staff to access quickly with bullet point instructions to follow during each level of lockdown for each facility. Hand hygiene and personal protective competencies were completed. Adequate supplies of personal protective equipment (PPE) and hand sanitizers were sighted. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. The policy includes restraint procedures. The policy identifies that restraint is used as a last resort. There were no enablers or restraints in use. The clinical manager/RN is the restraint coordinator. Training in restraint is held bi-annually. An education session on challenging behaviour has been provided in November 2020. The healthcare assistants interviewed were knowledgeable around restraint and enabler processes. |

# 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 1.3.12.6  Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines. | PA Low | An electronic medication system is in place with medications, dose and indications for use correctly documented. A controlled drug register is in place, with entries entered correctly as per policy by two medication competent staff. The register is checked by the pharmacist on a six-monthly basis, however the weekly check by staff has not been completed consistently on a weekly basis. | Controlled drug checks not always weekly with a gap of up to four weeks. | Ensure weekly control drug checks are completed.  90 days |
| Criterion 1.3.3.3  Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer. | PA Low | There were interRAI assessments and long-term care plans in place, however, not all of these had been completed or reviewed within timeframes. | (i). One initial interRAI assessment was not completed within 21 days of admission to the service (October 2020).  (ii). Two interRAI assessments were not reassessed within six months (one was last completed Oct 19, another had a 10 month gap).  (iii). Two of five long term care plans were not completed within three weeks (one new rest home resident admitted October didn’t have a care plan in place and one dementia resident admitted June 2020 did not have a care plan in place)  (iv). Three of five long term care plans were not reviewed at least six-monthly (one last completed October 2019, two had gaps of 10 month gaps between reviews). | (i)-(iv). Please ensure all interRAI assessments and long-term care plans are completed and reviewed within expected timeframes.  90 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 | There are monitoring charts in use for weight, neurological observations, blood sugar monitoring and food and fluid charts sighted. The monitoring charts were maintained as required, however, there were no behaviour monitoring charts used in the memory loss unit for residents with challenging behaviours. The use of behaviour monitoring charts was documented as a requirement in the meeting minutes. | Behaviour monitoring charts were not in place for two residents in the memory support unit with incident reports for challenging behaviours. | Ensure behaviour monitoring charts are in use as required in the memory support unit as per policy.  60 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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| No data to display |

End of the report.