

# Thorrington Village Limited - Thorrington Village

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## Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

**Legal entity:** Thorrington Village Limited

**Premises audited:** Thorrington Village

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

**Dates of audit:** Start date: 11 October 2017      End date: 12 October 2017

**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

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## Introduction

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

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

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

### Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

## General overview of the audit

Thorrington Village provides rest home and dementia level of care for up to 58 residents including rest home level across 13 studio apartments. On the day of audit there were 37 residents and one resident in a studio unit.

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

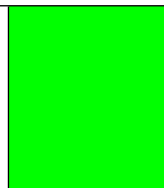
The owner of Thorrington Village also owns another local facility. The manager (non-clinical) has been in the role for two and half years supported by a clinical manager who has been in the role for six months. The residents and relatives spoke positively about the care and support provided at Thorrington Village.

The service has addressed two of four previous findings around notifying relatives of all accidents and incidents (A&I) and identifying opportunities for improvement.

Further improvements continue to be required around entries into progress notes and the updating interventions to reflect changes in health status. This audit also identified a further improvement required around activity assessment/care plan documentation.

## Consumer rights

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

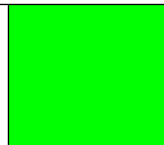


Standards applicable to this service fully attained.

Thorrington Village provides care in a way that focuses on the individual resident. Communication with residents and families is appropriately managed and documented. The complaints process is provided to residents and families as part of the admission process. A complaints register is in place that includes all complaints, dates and actions taken. Complaints are being managed in an appropriate manner and meet the requirements set forth 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.

Thorrington Village is implementing a quality and risk management system that supports the provision of clinical care. An annual resident satisfaction survey is completed and there are regular resident meetings. There is a monthly collation of quality data and this is discussed at quality and staff meetings. Internal audits are completed as per the annual audit schedule. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. The staffing policy aligns with contractual requirements and includes skill mixes.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Prior to entry to the service, residents are screened and approved. There is an admission package available prior to or on entry to the service that includes information on the services provided at Thorrington Village. The registered nurse is responsible for each stage of service provision. The registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family. Resident files included medical notes and notes of other visiting allied health professionals.

The facility was awaiting the commencement of a newly appointed, qualified, experienced diversional therapist. In the interim the diversional therapists from the villas and from the sister facility were providing interesting and varied activities programmes (memory support unit has a separate programme) for the residents that includes outings and community involvement.

Medication policies reflect legislative requirements and guidelines. The service uses an electronic medication system. Staff who are responsible for the administration of medicines, complete annual education and medication competencies. The general practitioner reviews medications three-monthly.

All meals are prepared on-site. Individual and special dietary needs are catered, and alternative options are available for residents with dislikes. A dietitian has reviewed the menu. Residents interviewed responded favourably to the food provided.

## 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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The building has a current warrant of fitness.

## 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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A restraint policy includes comprehensive restraint procedures. A documented definition of restraint and enablers aligns with the definition in the standards. There were no restraints or enablers in place. Staff have attended training in the management of challenging behaviour and minimisation of restraint.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator (CM) is responsible for coordinating education and training for staff. The infection control coordinator has attended external training. There are a suite of infection control policies and guidelines to support practice. The infection control coordinator uses the information obtained through surveillance to determine infection control activities and education needs within the facility.

## 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)
<b>Standards</b>	0	13	0	1	2	0	0
<b>Criteria</b>	0	36	0	1	2	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service has a complaints policy that describes the management of the complaints process. Information about complaints is provided on admission. The manager leads the investigation and management of complaints (verbal and written). Complaint forms are visible around the facility. Two complaints had been received year-to-date with evidence of appropriate and timely follow-up actions taken. A complaint to the Health &amp; Disability Commissioners Office in 2016 had resulted in one aspect of it not been validated and the second aspect remained under investigation. Documentation including follow-up communication and resolution demonstrates that the complaints were well managed.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Incident/accident forms reviewed include a section to record family notification. All forms sighted indicated family were informed. Relatives interviewed (one rest home, one dementia) confirmed they were notified of any changes in their family member's health status. The previous finding has now been addressed.</p>



<p><b>Standard 1.2.1: Governance</b></p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Thorrington provides rest home and dementia level care for up to 58 residents. On the day of audit, there were 36 rest home residents and one resident in a studio receiving care.</p> <p>On the day of audit, there were 26 residents (including one respite) receiving rest home level care across the 30 rest home rooms (two wings). There were 10 residents in a 15-bed dementia unit (five rooms are double). There are 13 studios certified for rest home level residents in another wing. There was one rest home resident in the studios.</p> <p>The site manager is supported by a clinical manager, a registered nurse and an enrolled nurse.</p> <p>Thorrington and the sister home have a full business plan which includes business objectives and quality objectives for each department. The overall general manager (owner) oversees these objectives with input from all levels of staff. Each objective has a strategic goal that includes timeframes with identified performance indicators. The site manager role incorporates the role of quality manager. The site manager demonstrated a good understanding of the quality cycle.</p> <p>The manager has maintained eight hours annually of professional development activities related to managing a rest home.</p>
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>Thorrington is implementing a quality and risk management system. There are policies and procedures implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are reviewed at least two yearly. The content of policy and procedures is detailed to allow effective implementation by staff. Caregivers interviewed confirm they are made aware of any reviewed policies.</p> <p>Quality matters and monthly data are discussed at the monthly quality and risk meetings. A senior person from each department attends these and information from these meetings and the monthly management meeting is fed back to the bi-monthly staff meeting. Infection control, and health and safety are incorporated into the quality and risk meetings, meeting minutes evidenced trending and analysis of quality data including accidents and incidents, infections and the use of enablers/restraint. Meeting minutes reviewed, including resident meetings, demonstrated that issues raised are followed through and closed out.</p> <p>An internal audit programme is followed with corrective actions followed up and</p>

		<p>addressed.</p> <p>Relative and resident satisfaction surveys are completed annually (the last surveys occurred in January 2017). Any areas surveyed that did not reach acceptable to very good have had corrective action plans written and corrective actions taken – there was evidence of actions having been taken.</p> <p>Falls prevention is managed on an individual basis with identified risks and interventions documented in the resident care plan. There is a current hazard register.</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 family/whānau of choice in an open manner.</p>	FA	<p>There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise risk. Twelve incident forms reviewed were fully completed and showed timely RN assessments and follow-up (also link 1.3.3.4). The previous finding had been fully addressed.</p> <p>Discussions with service management, confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been no notifications since previous audit.</p>
<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 to support recruitment practices. Current practising certificates are available in the RN files. Five staff files were reviewed (clinical manager, two caregivers, cook and cleaner) and all had relevant documentation relating to employment. Performance appraisals were current.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme includes documented checklists. Staff interviewed were able to describe the orientation process and believed new staff were adequately orientated to the service.</p> <p>There is a two-yearly education plan in place. All mandatory topics had been covered, including (but not limited to) managing challenging behaviour (May 2017), infection control (June 2017) and advocacy (September 2016). There is evidence that additional training opportunities have been offered to staff and 22 staff held a current first aid certificate. Interviews with caregivers and the registered nurse confirm training opportunities are available.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe</p>	FA	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. A roster provides sufficient and appropriate</p>

<p>service from suitably qualified/skilled and/or experienced service providers.</p>		<p>coverage for the effective delivery of care and support. Staffing is as follows: five caregivers in the morning plus RN or EN and a carer in the studios. Four care staff are on pm duty and three on night shift. The CM is on-site Monday to Friday and shares on-call with the RN. Of the above staff two care staff are in the dementia in the morning, one fulltime in the afternoon with a second until 7pm (then available as needed) and one on night. The caregivers, residents and relatives stated there is sufficient staff on duty at all times.</p>
<p>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.</p>	<p>FA</p>	<p>Medication policies align with legislative requirements and safe practice guidelines. The service uses an electronic medication system. The RN/EN and caregivers responsible for the administration of medications have completed six-monthly competencies and medication education. Medications are checked on arrival by the registered nurse/enrolled nurse and any pharmacy errors recorded and fed back to the supplying pharmacy. The CM, EN and care staff interviewed, were able to describe their role in medicine administration. Medications were stored safely. The medication fridge temperature was monitored weekly. Eye drops are dated on opening and there were no expired medications. There were no residents self-medicating.</p> <p>Standing orders were not in use.</p> <p>Ten medication charts and administration signing were viewed on the electronic medication system. Prescribing and three-monthly medication chart reviews met legislative requirements. The effectiveness of PRN medication was well recorded. Medication administration observed on audit met safe practice.</p>
<p>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.</p>	<p>FA</p>	<p>All food is prepared and cooked on-site at Thorrington Village. Three qualified cooks cover the seven-day week (one is currently undertaking chef training). They have completed food safety units. There was a rotating menu in place which a dietitian had reviewed September 2017.</p> <p>The food is prepared in the main kitchen and served directly to residents in the dining room. The cook receives resident dietary profiles and is notified of any dietary changes and requirements. Dislikes are accommodated. Fridge and freezer temperatures were recorded daily. Food temperatures had been taken and recorded daily. All foods were date labelled and stored correctly. A cleaning schedule is maintained. Registration had been completed for the council food plan with external audits completed. that the residents interviewed were happy with the food service. Relatives interviewed from the dementia unit said the food was good</p>

		and there were a lot of snacks available
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	PA Moderate	<p>When a resident's condition alters, the registered nurse initiates a review and if required, arranges a GP visit (link 1.3.3.4). There is evidence of three-monthly medical reviews or earlier for health status changes. Residents and relatives interviewed confirm care delivery and support by staff is consistent with their expectations. Families confirmed they were informed of any changes to resident's health status. Resident files reviewed included communication with family.</p> <p>Staff report there are adequate continence and dressing supplies. On the day of the audit, supplies of these products were sighted. There were no wounds on the day of audit. There were no pressure injuries. A wound management plan, evaluations and wound monitoring forms were evidenced for the last wound that a resident had. The CM/RN and EN interviewed could describe the referral process to a wound specialist or continence nurse.</p> <p>There were examples sited in the five care plans samples where interventions had been updated to reflect the changing status or needs of the individual resident. However, in two of five care plans reviewed specific interventions were lacking to support all assessed needs.</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>	PA Low	<p>The previous activities coordinator had left the role and the service has recently appointed a qualified and experienced diversional therapist (DT) Monday to Friday, who will be responsible for the planning and delivery of the activities programme commencing the week following audit.</p> <p>The service had identified changes they wished to make to the activities including changing documentation to "Tree of Life". These changes had commenced with nine residents having been assessed using this new documentation. The programmes (one for the dementia residents and one for rest home with some sharing as appropriate) were continuing. There was a variety of activities offered that are meaningful to the residents.</p> <p>Residents attend church services on-site and are supported to attend church in the community.</p> <p>Residents have an activity assessment completed on admission with an audit undertaken three months after admission. Activity plans were sighted in some resident files reviewed. Activity plans had been reviewed at the same time as care plans.</p>

		Residents in the rest home interviewed were overall happy with the activities programme. The two relatives interviewed (one rest home, one dementia)
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Evaluation of initial nursing assessment/care plans (sighted) was occurring within three weeks of admission. At present two systems were being used (some evaluations electronic/some paper based). InterRAI assessments are completed six monthly or earlier due to changes in health status. Long-term care plans are reviewed at least six-monthly by the multidisciplinary (MDT) team. Families are invited to attend the MDT meeting.  Short-term care plans have been reviewed regularly by the RN and either resolved or added to the long-term care plan if the problem is ongoing.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The building holds a current warrant of fitness expiring 1 July 2018.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator (CM) collates information obtained through surveillance to determine infection control activities and education needs in the facility. Data for all infections is collected and forwarded to the Presbyterian Support organisation who is collating and benchmarking all data (including key performance indicators) for Thorrington and its sister home. Definitions of infections are in place, appropriate to the complexity of service provided. Infection control data is collated monthly and discussed at both the quality and staff meetings. The surveillance of infection data assists in evaluating compliance with infection control practices. Internal audits for infection control are included in the annual audit schedule. There is close liaison with an IC specialist and Bug Control who advise and provide feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility.  There have been no outbreaks.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Thorrington has policies and procedures on restraint minimisation and safe practice. Policy includes guidelines and definitions for use of enablers and restraint. The clinical manager is the restraint coordinator with a job description defining responsibilities of the role. The restraint coordinator confirms that the service promotes a restraint-free environment. There are no residents assessed as

		requiring restraint or using enablers. Challenging behaviour and restraint minimisation and safe practice education has been provided. Restraint/enabler use is discussed at staff meetings. The caregivers interviewed were knowledgeable in the use of enablers/restraint.
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## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.3.4</p> <p>The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.</p>	<p>PA Moderate</p>	<p>There is a verbal and written handover at each shift with the home assistants writing progress notes each duty. There is little evidence that RNs make entries into progress notes. One file reviewed had no evidence of RN progress notes. The previous finding of registered nurses not regularly entering in progress notes remains open</p>	<p>Five files reviewed did not evidence regular RN entries in progress notes following changes in health status and following RN assessment.</p>	<p>Ensure progress notes evidence follow up review and assessment by registered nurses</p> <p>60 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, and desired outcomes.</p>	<p>PA Moderate</p>	<p>The respite file reviewed included a short-term care plan that identified assessed needs. There were no current wounds, however previous wound documentation was reviewed which evidenced assessment, management and evaluation. Aspects of the previous finding has been addressed. Monitoring charts are in use where required. De-</p>	<p>There are detailed handovers between staff informing of resident status, however, the documentation of all detail was lacking. In two of five care plans reviewed specific interventions were lacking to support all assessed needs. Example: (i) one resident had a change of health status and need that was not reflected in the care plan and (ii) another</p>	<p>Ensure interventions are documented to support all current needs</p> <p>60 days</p>

		<p>escalation techniques are documented for behaviours that challenge</p> <p>There were examples sited in the five care plans samples where interventions had been updated to reflect the changing status or needs of the individual resident. However, in two of five care plans reviewed specific interventions were lacking to support all assessed needs. This criterion remains an area for improvement.</p>	<p>resident had a significant anxiety disorder but there was no mention of this or possible interventions to minimise the anxiety.</p>	
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	<p>PA Low</p>	<p>The role of DT was vacant with activities being provided for the residents by the DT from the sister home and the DT from the units in the village. All four long term files of residents showed assessments, planning and review had not occurred or were out of date.</p>	<p>All four long-term files did not have up to date activity assessments, activity plans, or reviews.</p>	<p>Ensure all long-term residents receive an activities assessment and plan and these are reviewed at least 6 monthly with the care plan review</p> <p>90 days</p>



## Specific results for criterion where a continuous improvement has been recorded

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As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

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End of the report.