

# Norfolk Lodge Waitara Limited

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## 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:

<b>Legal entity:</b>	Norfolk Lodge Waitara Limited
<b>Premises audited:</b>	Norfolk Lodge Rest Home
<b>Services audited:</b>	Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 2 February 2015      End date: 3 February 2015
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	35

# 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
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

Norfolk Lodge is a privately owned aged care facility. The service provides care for up to 40 residents at rest home level and dementia level care. On the day of the audit, there were 35 residents in total.

This certification audit was conducted against the relevant Health and Disability standards and the contract with the District Health Board. The audit process included a review of policies and procedures; the review of resident's and staff files, observations and interviews with residents, relatives, staff and management. The nurse manager is appropriately qualified and experienced. There are implemented quality systems and processes that are embedded throughout the organisation. Feedback from residents and relatives is positive about the care and services provided. An induction and in-service training programme is provided. Residents and families interviewed were very complimentary of care and support provided.

There is one required improvement around resident needs reassessment. The service has exceeded the required standard around meeting the needs of Maori and staff education.

## 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.		All standards applicable to this service fully attained with some standards exceeded.
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The staff at Norfolk Lodge ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and services is easily accessible to residents and families. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Informed consent processes are followed and residents' clinical files reviewed evidence informed consent and advanced directives are documented. Complaints and concerns have been managed and a complaints register is maintained.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Norfolk Lodge has a quality and risk management system in place that is implemented and monitored, which generates improvements in practice and service delivery. Key components of the quality management system link to staff meetings. The service is active in analysing data with recent evidence of annual review of all aspects of the quality and risk management programme. Corrective actions are identified and implemented. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and appropriately managed. There is a comprehensive orientation programme that provides new staff with relevant and specific information for safe work practice. The in-service education programme covers relevant aspects of care and support and exceeds the expected standard. The staffing levels provide

sufficient and appropriate coverage for the effective delivery of care and support. Staffing is based on the occupancy and acuity of the residents.

## 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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The service has adopted InterRAI for its assessments and care planning process. The residents' needs, interventions, outcomes/goals have been identified and these are reviewed on a regular basis with the resident and/or family/whanau input. Care plans demonstrate service integration. Care plans are reviewed six monthly, or when there are changes in health status. Resident files include notes by the GP and allied health professionals.

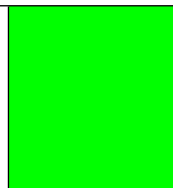
Medication policies and procedures are in place to guide practice. Education and medication competencies are completed by all staff responsible for administration of medicines. The medicines records reviewed include documentation of allergies and intolerances.

The activities programme is facilitated by diversional therapists. The activities programme provides varied options and activities are enjoyed by the residents. The programme caters for the individual needs. Community activities are encouraged; van outings are arranged on a regular basis.

All food is cooked on site by the in house cook. All residents' nutritional needs are identified, highlighted and choices available and provided. Meals are well presented.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.



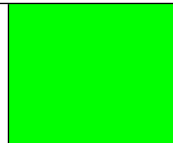
Standards applicable to this service fully attained.

The service has implemented policies and procedures for civil defence and other emergencies and six monthly fire drills are conducted.

Chemicals are stored securely throughout the facility. Appropriate policies are available along with product safety charts. The building holds a current warrant of fitness. Resident rooms are large enough for rest home and dementia level residents. External areas are safe and well maintained. The facility has a van available for transportation of residents. There are lounges in each area. There are adequate toilets and showers for the client group. Fixtures fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are monitored through the internal auditing system. Appropriate training, information and equipment for responding to emergencies is provided. There is an approved evacuation scheme and emergency supplies for at least three days. All key staff hold a current first aid certificate. The facility has heating and temperature is comfortable and constant.

## 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.

There is a restraint policy that included comprehensive restraint procedures and aligns with the standards. A register is maintained with all residents with restraint or enablers. There was one resident requiring restraint and no residents using enablers.

Appropriate assessment, monitoring and evaluation of restraint use have occurred. The service reviews restraint as part of the quality management and staff are trained in restraint minimisation.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.

Standards applicable to this service fully attained.

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. Documented policies and procedures are in place for the prevention and control of infection and reflect current accepted good practice and legislative requirements. Infection control education is provided to all service providers as part of their orientation and also as part of the on-going in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Results of surveillance are acted upon, evaluated and reported to relevant personnel.

## 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>	1	48	0	1	0	0	0
<b>Criteria</b>	2	98	0	1	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)
<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 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Discussions with staff confirmed their familiarity with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Seven residents (from the rest home) and five relatives (three from the rest home and two from the dementia unit) were interviewed and confirmed the services being provided are in line with the Code.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Informed consent and advanced directives were recorded as evidenced in the seven resident files reviewed (three rest home and four dementia). Advised by staff that family involvement occurs with the consent of the resident. This was confirmed by families interviewed. Residents interviewed confirmed that information has been provided to enable informed choices and that they were able to decline or withdraw their consent. Resident admission agreements were signed.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>Contact numbers for advocacy services are included in the policy, in the resident information folder and in advocacy pamphlets that are available at reception. Residents' meetings include discussing previous meeting minutes and actions taken (if any) before addressing new items. Discussions with relatives identified that the service provides opportunities for the family/EPOA to be involved in decisions.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Residents and relatives confirmed that visiting can occur at any time. Key people involved in the resident's life have been documented in the care plans. Residents and relatives verified that they have been supported and encouraged to remain involved in the community. Entertainers have been invited to perform at the facility.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>A complaints policy and procedures have been implemented and residents and their family/whānau have been provided with information on admission. Complaint forms are available at the entrance of the service. Staff are aware of the complaints process and to whom they should direct complaints. A complaints folder has been maintained. Three complaints were received in 2014 and review of these shows appropriate processes and adherence to time frames. Residents and family members advised that they are aware of the complaints procedure and how to access forms.</p> <p>E4.1biii: There is written information on the service philosophy and practices particular to the dementia unit included in the information pack</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>The service provides information to residents that include the Code, complaints and advocacy. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Residents and relatives interviewed identified they are well-informed about the code of rights. Resident meetings and a resident and family survey provide the opportunity to raise concerns. Advocacy and code of rights information is included in the information pack and are available at reception.</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>Staff interviewed were able to describe the procedures for maintaining confidentiality of resident records, resident's privacy and dignity. House rules and a code of conduct are signed by staff at commencement of employment. Church services are held at least twice weekly from a variety of denominations and resident files include cultural and spiritual values. Contact details of spiritual/religious advisors are available to staff. The service has a Maori chaplain who visits weekly or more often if required. Residents and relatives interviewed reported that residents are able to choose to engage in activities and access community resources. There is an elder abuse and neglect policy and staff education and training on abuse and neglect has been provided.</p> <p>E4.1a The two family members from the dementia unit interviewed stated that their family member was welcomed into the unit and personal pictures were put up to assist them to orientate to their new environment.</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>CI</p>	<p>The service has a Maori health plan and an individual's values and beliefs policy which includes cultural safety and awareness. Discussions with staff confirmed their understanding of the different cultural needs of residents and their whānau. There are currently 26% of residents and 66% of staff who identify as Maori. The service has established links with local Maori and staff confirmed they are aware of the need to respond appropriately to maintain cultural safety. The recognition of Maori values and beliefs exceeds the required standard.</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 respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>Care planning includes consideration of spiritual, psychological and social needs. Residents interviewed indicated that they are asked to identify any spiritual, religious and/or cultural beliefs. Relatives reported that they feel they are consulted and kept informed and family involvement is encouraged.</p>

<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>The staff employment process includes the signing of house rules and a service code of conduct. Job descriptions include responsibilities of the position and ethics, advocacy and legal issues. The orientation programme provided to staff on induction includes an emphasis on dignity and privacy and boundaries. The nurse manager has completed training around professional boundaries.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The quality programme has been designed to monitor contractual and standards compliance and the quality of service delivery in the facility. Staffing policies include pre-employment, and the requirement to attend orientation and on-going in-service training. The administrator, with support from the nurse manager is responsible for coordinating the internal audit programme. Regular staff meetings and residents meetings have been conducted.</p> <p>Residents and relatives interviewed spoke very positively about the care and support provided. Staff have a sound understanding of principles of aged care and state that they feel supported by the nurse manager. Care staff complete competencies relevant to their practice.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Residents and family members interviewed stated they were informed of changes in health status and incidents/accidents. Residents and family members also stated they were welcomed on entry and were given time and explanation about services and procedures.</p> <p>Resident/relative meetings occur three monthly and the nurse manager has an open-door policy. Residents and family are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The service has policies and procedures available for access to interpreter services for residents (and their family/whānau). If residents or family/whānau have difficulty with written or spoken English the interpreter services are made available. Twenty of the 30 staff speak Te Reo and frequently communicate with Maori residents in Te Reo (link 1.1.4.3).</p>

<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Norfolk Lodge is privately owned. The service provides care for up to 40 residents at rest home level and dementia level care. On the day of the audit, there were 35 residents in total (19 residents at rest home level and 16 residents in the secure dementia unit).</p> <p>The service has been managed by an experienced nurse manager who has been in the role for nine years, having worked previously at the service as her caregiver before completing nursing training. The nurse manager speaks at least daily to the director who visits the service at least monthly. The current business plan and quality and risk management plans have been implemented. The nurse manager has well exceeded eight hours of training relating to the management of a rest home in 2014.</p> <p>The 2015 business plan documents the mission and philosophy of the organisation (which includes providing safe and therapeutic care for residents with dementia that enhances their quality of life and minimises risks associated with their confused states) and objectives for the year. It includes a review of the 2014 goals.</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>	<p>FA</p>	<p>The administrator and a senior assistant (a senior caregiver) provide cover during a temporary absence of the nurse manager with clinical support from a registered nurse who is familiar with Norfolk Lodge.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</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>The 2015 business and quality plans describe the Norfolk Lodge's quality improvement processes. The risk management plan describes objectives, management controls and assigned responsibility. Progress with the quality and risk management programme has been monitored through the monthly staff meetings. Monthly and annual reviews have been completed for all areas of service. Meeting minutes have been maintained and staff were expected to read the minutes and sign off when read. Minutes for all meetings have included actions to achieve compliance where relevant. Discussions with staff (including three caregivers, two senior assistants, two ACE assessors and two diversional therapists) confirmed their involvement in the quality programme. Resident/relative meetings have been held three</p>

		<p>monthly. Data is collected on complaints, accidents, incidents, infection control and restraint use. The internal audit schedule for 2014 has been completed and the 2015 schedule commenced. Areas of non-compliance identified at audits have been actioned for improvement. Specific quality improvements have been identified. The service has implemented a health and safety management system. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. The service has comprehensive policies/ procedures to support service delivery. Policies and procedures align with the client care plans. A document control policy outlines the system implemented whereby all policies and procedures are reviewed regularly. The death/Tangihanga policy and procedure that outlines immediate action to be taken upon a resident's death. Falls prevention strategies are implemented for individual residents. Residents' are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families.</p>
<p><b>Standard 1.2.4: Adverse Event Reporting</b> 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>Incident and accident data has been collected and analysed. Discussions with the service confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. A sample of resident related incident reports for January 2015 were reviewed. All reports and corresponding resident files reviewed evidence that appropriate clinical care has been provided following an incident. The incident reporting policy includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Monthly and annual review of incidents informs quality initiatives.</p>
<p><b>Standard 1.2.7: Human Resource Management</b> Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>The recruitment and staff selection process requires that relevant checks have been completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates have been kept. Seven staff files were reviewed and included all appropriate documentation. Staff turnover was reported as low, with some staff having been employed in excess of 20 years. The service has a</p>

		<p>comprehensive orientation programme that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. Annual appraisals are conducted for all staff. A completed in-service calendar for 2014 exceeded eight hours annually. The staff education opportunities exceed the standard required. The nurse manager attend external training including conferences, seminars and education sessions with the local DHB.</p> <p>E4.5d: The orientation programme is relevant to the dementia unit and includes a session on how to implement activities and therapies.  E4.5e: The service does not use agency staff  E4.5f: There are 13 caregivers who work in the dementia unit. All 13 have completed the required dementia standards.</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>	<p>FA</p>	<p>Norfolk Lodge has a weekly roster in place which provides sufficient staffing cover for the provision of care and service to residents. There is a registered nurse (the nurse manager) on duty or on call at all times. In her absence another registered nurse provides cover. Caregivers and residents and family interviewed advised that sufficient staff are rostered on for each shift. All staff have been trained in first aid and CPR.</p>
<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>	<p>FA</p>	<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. Residents' files are protected from unauthorised access by being in locked cupboards. Notices or documents containing sensitive resident information are not displayed in a way that can be viewed by other residents or members of the public. Record entries are legible, dated and signed by the relevant staff member. Individual resident files demonstrate service integration. Medication charts have been stored in a separate folder.</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>	<p>FA</p>	<p>Norfolk Lodge Rest Home have a well-developed assessment process and residents' needs are assessed on entry. The service has an admission policy including: a) admission documentation, b) admission agreement, c) consent information and residents and/or relatives are provided with information in relation to the service. Information gathered at admission is retained in the residents' records. The residents and family members interviewed stated they were well informed upon admission.</p> <p>E4.1.b There is written information on the service philosophy and practices. Included in the information pack is dementia specific documentation for those entering the dementia care unit.</p> <p>D13.3 The admission agreement reviewed aligns with a) -k) of the ARC contract.</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>	<p>FA</p>	<p>There is a transfer plan policy. A record is kept and a copy is kept on the resident's file. This was sighted in one resident file (from the rest home) where the resident had been transferred to hospital acutely. All relevant information is documented and communicated to the receiving health provider or service.</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 medication policies in place. All medication administering follows safe medication guidelines as set down in the policies.</p> <p>Medication fridge temperatures are monitored weekly. Medication reconciliation is completed on admission and the policy includes guidelines on checking medications on arrival. All staff administering medications have completed an annual medication competency. At the time of audit there were no residents' who were self-administering medications. Twelve medication charts were reviewed. All meet legislative guidelines and administration charts were documented accurately.</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>Norfolk Lodge Rest Home has a large, well equipped kitchen. The menu designed by a dietitian. There is a summer and winter six week rotational menu.</p> <p>All meals are prepared in the main kitchen and served from the kitchen directly to the residents' in the main dining room and dementia care dining room. Diets are modified as required. The cook confirmed that there is an alternative available. Any changes to nutritional requirements are communicated to the cook by the registered nurse.</p> <p>Kitchen fridge, freezer and food temperatures are monitored and documented. In the dementia care unit additional snacks were available to residents 24 hours a day.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>There were records kept of reasons for any declined entry; due to there being no beds available or else the unavailability of required level of care (for example the need for a hospital or psychogeriatric care). On interview management were able to discuss the process of declined entry and support and alternatives for those declined.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>Norfolk Lodge Rest Home have adopted the InterRAI assessment tool as evidenced in resident files sampled. These were reviewed at least six monthly and are used to effectively assess level of risk and required support.</p> <p>Appropriate personal needs information is gathered during admission Needs outcomes and goals of consumers are identified.</p> <p>ARC E4.2; D16.2; All resident files reviewed included an individual assessment that included identifying diversional, motivation and recreational requirements.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Care plans demonstrate service integration and demonstrate input from allied health professionals. All short term and long term care plans reviewed were completed by the nurse manager.</p> <p>Care plans reviewed provide evidence of individualised support and</p>

		<p>include interventions for all assessed needs.</p> <p>E4.3 Resident files reviewed identified current abilities, level of independence, identified needs and specific behavioural management strategies.</p> <p>D16.3k, Short term care plans were in use for changes in health status.</p> <p>D16.3f; Resident files reviewed identified that family were involved.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Seven resident files were reviewed. The care plans were well documented. All residents' interviewed stated their needs were being appropriately met.</p> <p>Dressing supplies are available and a treatment room is stocked for use. Continence products are available and were identified for daytime and night use, plus any other management. Procedures for wound assessments, evaluation and nursing interventions were in place as evidenced in the wound management folder. However, there were no wounds identified at time of audit.</p> <p>The general practitioner (GP) was not available for interview.</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>The two diversional therapists provide an activities programme over five days each week with separate programmes in the dementia unit and rest home and some combined activities. One of the diversional therapist works five hours per week specifically providing 1:1 activities for those who do not wish or are not able to join the group activities. There are two caregivers who work in the dementia unit who are trained diversional therapists and provide activities in dedicated time every afternoon. The programme is planned monthly and residents receive a personal copy of planned monthly activities. A diversional therapy plan was developed for each individual resident based on assessed needs. Residents are encouraged to join in activities that were appropriate and meaningful and are encouraged to participate in community activities. The service has a van that is used for resident outings. Residents were observed participating in activities on the days of audit. Resident meetings provided a forum for feedback relating to activities. Residents and family members interviewed</p>

		discussed enjoyment in the programme and the diversity offered to all residents.
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The evaluation and care plan review policy require that long term care plans are reviewed six monthly, or as residents' condition changes. The evaluations describe progress against set goals and needs identified in the care plan. Short term were utilised when required. Any changes to the long term care plan were dated and signed by the registered nurse.</p> <p>All initial care plans cited were reviewed by the nurse manager within three weeks.</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>	PA Low	<p>Referral to other health and disability services is evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files.</p> <p>D 20.1 Discussions with the nurse manager identified that the service has access to specialist nursing services such as continence nurses, palliative care services and wound specialist nurses.</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>	FA	<p>All chemicals are labelled with manufacturer labels. There are designated areas for storage of cleaning/laundry chemicals and chemicals were stored securely. Product use charts were available and the hazard register identifies hazardous substances. Gloves, aprons, and goggles are available for staff. Safe chemical handling training has been</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>Norfolk Lodge Rest Home provides a clean and safe environment, which are well maintained and appropriate for its purpose. The dementia care unit is clean and secure with well-presented outdoor areas for both rest home and dementia care. There is a van available for trips. Reactive and preventative maintenance occurs. The building</p>

		<p>holds a current warrant of fitness. Electrical equipment is checked annually.</p> <p>The external areas are well maintained and gardens are attractive. There is wheelchair access to all areas.</p> <p>E3.4d: The lounge area is designed so that space and seating arrangements provide for individual and group activities.</p> <p>ARC D15.3: All required equipment is available.</p> <p>E3.3e: There are quiet, low stimulus areas that provide privacy when required.</p> <p>E3.4.c: There is a safe and secure outside area that is easy to access off the dementia unit. The outside area for residents in the dementia unit is well designed and appropriate for residents who like to walk about.</p>
<p><b>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</b></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>	FA	<p>The rest home and dementia units evidenced sufficient toilets and showers for the resident population. There is also adequate toilet facilities for use by staff and visitors. Communal toilets and bathrooms have appropriate signage and shower curtains installed.</p>
<p><b>Standard 1.4.4: Personal Space/Bed Areas</b></p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>The rooms are spacious and it can be demonstrated that wheel chairs, hoists and the like can be manoeuvred around the bed and personal space, for those indicated. Caregivers interviewed report that rooms have sufficient room to allow care to take place. Residents interviewed voiced their satisfaction for the size of their bedrooms.</p>
<p><b>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</b></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 is a lounge and separated dining rooms in both the dementia unit and rest home. All lounge/dining rooms are also accessible and accommodate the equipment required for the residents. Residents are able to move freely and furniture is well arranged to facilitate this.</p> <p>ARC E3.4b: There is adequate space in the dementia unit to allow maximum freedom of movement while promoting safety for those that wander.</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>	<p>FA</p>	<p>All laundry is done on site and there are dedicated laundry and cleaning staff. The laundry and cleaning room are designated areas and clearly labelled. Chemicals are stored in a locked room. All chemicals are labelled with manufacturer's labels. There are sluice rooms for the disposal of soiled water or waste. These are locked when unattended. Residents interviewed confirmed that the facility was kept clean.</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>	<p>FA</p>	<p>The service has a fire and emergency procedures manual. The fire evacuation scheme was approved in 2000. There is a staff member with a first aid certificate on each shift. Fire safety training has been provided. A call bell light over each door and a panel in the corridor alerts staff to the area in which residents require assistance. Fire drills have been conducted six monthly. Civil defence and first aid resources were available. Sufficient water is stored in the swimming pool with purification tablets available for emergency use and alternative heating and cooking facilities are available. Emergency lighting is installed. Security checks have been conducted each night by staff.</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>	<p>FA</p>	<p>The facility has overhead/ceiling heating, heat pumps and wall mounted heaters which can be controlled in each area/room; rooms were well ventilated and light. Facility temperatures are monitored monthly. There is plenty of natural light in resident's rooms.</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>	<p>FA</p>	<p>Norfolk Lodge has an established infection control (IC) programme. The infection control programme has been appropriate for the size, complexity and degree of risk associated with the service. The nurse manager has been the designated infection control coordinator. The IC team meets to six monthly review infection control matters. Infection control is discussed every month at the staff meeting. Regular audits have been conducted and education has been provided</p>

		for staff. The infection control programme has been reviewed annually.
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	There are adequate resources to implement the infection control programme at Norfolk Lodge. The infection control (IC) coordinator has maintained her practice by completing Ministry of Health online training in 2015. The infection control team is representative of the facility. External resources and support are available when required. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.
<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>	FA	The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes roles, responsibilities, procedures, the infection control team and training and education of staff. The policies are reviewed and updated at least annually.
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	The facility is committed to the on-going education of staff and residents. Education is facilitated by the infection control coordinator. All infection control training has been documented and a record of attendance has been maintained. The nurse manager reported that visitors would be advised of any outbreaks of infection and would be advised not to attend until the outbreak had been resolved (there have been no outbreaks). Information is provided to residents and visitors that is appropriate to their needs and this was documented in medical records sampled. Education around infection prevention and control has been provided in 2014.
<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</p>	FA	Infection surveillance and monitoring is an integral part of the infection control programme and is described in infection control policy. Monthly infection data is collected for all infections based on signs and

infection control programme.		symptoms of infection. Monthly graphs of organism and types of infection are developed and provided to staff and the annual review of infection rates included quality improvement initiatives to reduce infection rates. Surveillance data is discussed at every monthly staff meeting.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The service is committed to restraint minimisation and safe practice was evidenced in the restraint policy and interviews with staff. Restraint minimisation is overseen by a restraint coordinator who is the nurse manager. There is one resident requiring bedrails, a fall out chair and a lap belt as restraint (in the rest home). There were no enablers in use. The relative of the resident using the restraint was interviewed and is confident this is the best and safest alternative for the resident who is not competent to consent. There is a documented definition of restraint and enablers in the policies, which is congruent with the definition in NZS 8134.0. The restraint standards are being implemented, which is reviewed through internal audits, facility meetings. Training and competencies have been completed by staff, where appropriate.
Standard 2.2.1: Restraint approval and processes Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.	FA	Restraint approval is clearly documented in the restraint minimisation and safe practice policy with the restraint coordinator (the nurse manager), the GP and the family involved in the approval process. Staff have had training in restraint minimisation and the management of behaviours that challenge.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	The file of the resident with restraint includes a detailed assessment documenting the reason for restraint, any alternatives tried, cultural safety around restraint and the risks of restraint.  Policies provide guidance regarding assessments of using restraints and enablers.

<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>The restraint register documents that restraint has been discontinued for one resident as alternatives were found and documents that one resident has restraint. The restraint monitoring form documents the type of restraint, the times on and off and any interventions and repositions provided. Restraint and the management of risks related to the use of restraint are included in the care plan.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>There is an annual formal evaluation of the restraint which includes all the elements required in criterion 2.2.4.1. The evaluation includes caregivers, the family, the nurse manager and the GP. Review of the restraint use is documented in the monthly staff meeting minutes.</p> <p>The service documents the monitoring of restraints as per policies.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>There is an annual restraint group meeting to review the use of any restraints each year. Restraint and the use of restraint are discussed every month at the staff meeting as a standing agenda item. There is an annual audit of restraint practices.</p> <p>Norfolk Lodge demonstrated the continued documented evidence of restraint monitoring and reviews.</p>



## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.9.1</p> <p>Consumers are given the choice and advised of their options to access other health and disability services where indicated or requested. A record of this process is maintained.</p>	PA Low	Referral to other health and disability services is evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files.	The rest home tracer resident requires a sling hoist and restraint. Staff and family interviewed confirmed they were happy with the care provided at Norfolk. However, the resident has not been reassessed with the increased level of acuity.	<p>Ensure resident is reassessed. If the resident is reassessed as requiring a higher level of care, then the service obtain documented approval to continue to manage the residents care.</p> <p>30 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, 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 1.1.4.3</p> <p>The organisation plans to ensure Māori receive services commensurate with their needs.</p>	CI	<p>Norfolk Lodge provide services to a high number of Maori residents. The manager and staff describe a passion for improving the lives of Kaumatua and Kuia and all staff spoken to reflect this commitment.</p>	<p>Staff and management at Norfolk Lodge have a particular focus on ensuring the needs of Maori residents and staff are met. 26% of residents and 66% of staff at Norfolk Lodge identify as Maori. During the audit several staff were witnessed to be engaging with different residents in Te Reo. Twenty of the 30 staff at the service are able to converse in Te Reo and the one Maori dementia family member and one rest home family member whose relatives identify as Maori report that this has a big impact on the cultural and emotional wellbeing of the residents.</p> <p>The service has a Maori chaplain who visits at least weekly to support residents and staff. This person also blesses rooms and staff and residents after any significant event requiring this. All meetings begin and end with karakia.</p> <p>The service has a link with a local Maori provider and through networking residents can go on weekly outings and take part in local events. This includes the provision of mirimiri and other cultural treatments. This organisation also supports residents who wish to</p>

			<p>apply for grants for items such as mobility scooters and in partnership with Norfolk Lodge took part in WERO, a stop smoking challenge facilitated by the Public Health unit of the DHB, a whanau concept with kaimahi / colleagues supporting each other in the workplace to give up smoking. Some of the techniques included identifying triggers and how to deal with them and having a supportive team behind those trying to give up. Throughout the challenge teams were given regular contact with a quit coach from the Maori Public Health unit and spot prizes are awarded to those taking part. The challenge resulted in the Norfolk Lodge team coming second, and a number of participants (including one resident) who stopped smoking for good, and whose story is featured on a nationwide stop smoking campaign.</p> <p>The local Kohanga Reo children regularly perform plays, waiata and kapa haka performances for residents including for kaumatua birthday parties and other festivities. Additionally a local Maori kapa haka group perform kapa haka and waiata at Christmas for residents every year.</p> <p>A staff member is the chair of the local iwi board and is the iwi representative on local DHB. This person attends meetings and that management and staff are included in cultural awareness / iwi issues. The local iwi radio station network promotes Norfolk Lodge and does birthday calls for residents and tributes to those who have passed on over the air and promotes events happening with the home and staff. Seven residents interviewed report the link with the radio station as a positive influence on their enjoyment of local community life and in meeting their cultural needs. In the 2013 and 2014 Iron Maori Taranaki, Norfolk Lodge supported staff to focus on health and fitness, with a total of 18 past and present staff members competing both years in the Iron Maori Taranaki competition with six teams of three in the short course relay event. Staff training outside of work in groups and as individuals in preparation for the event, which included swimming, cycling, running or walking provided support in maintaining a healthy lifestyle for Maori staff. The service has strong connections with local marae Ratana affiliations that support with spiritual / cultural needs of staff and residents when requested. There is also input from local marae and hapu through</p>
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			<p>another marae in Waitara.</p> <p>When a resident passes away (no matter what their cultural affiliation, but in keeping with Maori culture), staff remain with that person until they leave the premises, and form a guard of honour from the front door to the hearse to see them off the premises. Management and staff will go to the tangi and during the audit management were witnessed arranging to provide transport to a regular respite resident (who is Maori) to attend a tangi. When a person has passed, the room is blessed by the Chaplain before it is let to another resident, and the chaplain provides a blessing for the staff if they request this. Traditional Maori kai (food) is cooked by the service at least fortnightly and is available for our Maori residents and others who enjoy it. Residents and families interviewed commented positively about the provision of traditional kai.</p> <p>The recreation programme recognises Waitangi day and all other significant cultural days which are celebrated with events as documented on the February activity calendars for both the rest home and dementia unit. Examples of activities include discussions about New Zealand history including partnerships and reminiscing, newspaper readings and watching relevant television programmes as well as traditional kai being available on such days. Residents also attend outings to primary school kapa haka competitions and performances that relate to Puanga and Matariki. There are weekly Kaumatua meetings at Norfolk Lodge.</p>
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	<p>CI</p>	<p>The service has two staff that are ACE assessors and have dedicated time each month to the provision of education. Staff report a very high level of satisfaction with the training provided.</p>	<p>One of the objectives of Norfolk Lodge is to have more highly qualified staff.</p> <p>Through the Health Work Force New Zealand Funding Hauora Maori Training Funding Scheme administered by the Taranaki District Health Board, Norfolk Lodge supports their Maori caregivers in applying and being successful in obtaining funding for further education towards National Level 3 and National Level 4 NZQA certificates. They now have four qualified diversional therapists and two qualified work place ACE Assessors on site and a high number of staff having at least two NZQA Level 3 Certificates. This saw Norfolk lodge nominated for healthcare excellence awards in 2013</p>

			<p>and 2014. In 2013 Norfolk Lodge was chosen as a finalist for its achievement in the staff training and development section at the awards.</p> <p>The organisation provides resources for staff education including 12 hours per week divided over two staff, both of who have recently qualified as ACE assessors to develop, implement and monitor the education programme. Of the 24 care staff four have completed diversional therapy qualifications, 16 have completed the ACE national certificate, 21 the ACE dementia course and 21 the ACE core qualification. The two education resource staff provide workshops for small groups of staff that fit around their rostered hours to support them with the completing of ACE modules. The four kitchen staff were also recently supported to complete an NZQA food safety qualification and all passed with pass rates between 90 and 98%. In addition to caregiving specific qualifications one staff member has completed a level three and four diploma in business and computing and a diploma in Te Reo Maori, another level three computing and a level two Te Reo Maori course and another the level two Te Reo Maori course. Two staff have recently completed level four courses and another has successfully achieved university entrance. External training has also been provided for individual and small groups on nine occasions in the past two years including five staff and the manager attending an Aged Care conference in Auckland in 2013 and two staff attending in Wellington in 2014.</p> <p>The service has a two year rolling calendar of in-service training that covers all required topics with cultural safety, resident's rights and infection control being covered annually. There is a high attendance rate and if a staff member is not able to attend a training session they are provided with a hand-out and a competency assessment which they must complete. If required one of the two education resource staff will spend 1:1 time with the staff member to ensure they pass the competency assessment and understand the topic the training was about. All competency assessments are kept in the individual staff members training file.</p>
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End of the report.