Norfolk Lodge Waitara Limited

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:	Norfolk Lodge Waitara Limited
Premises audited:	Norfolk Lodge Rest Home
Services audited:	Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 13 July 2016 End date: 13 July 2016

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 32

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

Indicator	Description	Definition
	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

Norfolk Lodge Waitara Limited (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 32 residents.

This unannounced surveillance audit was conducted against a subset of the 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. Feedback from residents and relatives is positive.
The shortfall identified at the previous audit around residents requiring care at a higher level has been addressed.

The service continues to exceed the required standard around 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.		Standards applicable to this service fully attained.

Residents and family are well informed including of changes in resident's health. The nurse manager has an open door policy. Complaints processes are implemented. Complaints and concerns are managed and documented and learning's from complaints shared with all staff.

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.

Norfolk Lodge has an established quality and risk management system that supports the provision of clinical care and support.

The service is managed by an experienced manager who has been in the role for eleven years. Quality management processes are reflected in the businesses plan's goals, objectives and policies. A risk management programme is in place, which includes a risk management plan, incident and accident reporting and health and safety processes. Incidents and accidents are documented by staff.

Residents receive appropriate services from suitably qualified staff. Recruitment is managed in accordance with good employment practice and meeting legislative requirements. An orientation programme is in place for new staff with ongoing education and training provided.

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.		Standards applicable to this service fully attained.

The manager takes primary responsibility for managing entry to the service. Comprehensive service information is available. Initial assessments are completed by the manager (registered nurse), including interRAI assessments. The manager completes care plans and evaluations within the required timeframes. Care plans are based on the interRAI outcomes and other assessments. They are clearly written and caregivers report they are easy to follow. Residents interviewed confirmed they were involved in the care planning and review process. Each resident has access to an individual and group activities programme. Medicines are stored and managed appropriately in line with legislation and guidelines. General practitioners review residents at least three monthly or more frequently if needed. Meals are prepared on-site by qualified chefs. The menu is varied and appropriate and reviewed annually by a dietitian. Individual and special dietary needs are catered for and nutritious snacks are available over the 24 hour period. Residents interviewed were complimentary about the food service.

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 building holds 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.

There is a restraint minimisation policy that includes restraint procedures including restraint minimisation. There is a documented definition of restraint and enablers that aligns with the definition in the standards. There is one restraint and no enablers being used. Enabler use is voluntary.

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.

The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	17	0	0	0	0	0
Criteria	1	39	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The service has a complaints policy that describes the management of the complaints process. Complaints forms are available. Information about complaints is provided on admission. The manager operates an "open door" policy. Residents and relatives confirmed they are aware of the complaints process. A record of all complaints is maintained by the facility using the complaints register. There was one complaint for 2016. Documentation including the follow-up letter and resolution reviewed demonstrated that the complaint was well managed. There is written information on the service philosophy and practices particular to the dementia unit included in the information pack.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective	FA	There is an open disclosure policy in place. Residents are provided with a range of information on admission regarding the scope of service and any items they have to pay that is not covered by the agreement. An interpreter is provided as required. Two relatives and five residents agreed that the service maintains a high level of communication and that 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. Resident/relative meetings occur three

communication.		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. Twenty-six of the thirty-four staff speak Te Reo Māori and frequently communicate with Māori residents in Te Reo Māori. Nine of nine resident related incident forms reviewed for May and June 2016 identified family were notified (five rest home and four dementia). Resident meetings encourage open discussion around the services provided (meeting minutes sighted). Residents meetings occur where any issues or concerns to residents are able to be discussed, six monthly resident surveys are completed around care and food services. (Minutes viewed).
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Norfolk Lodge is a privately owned service. It provides rest home and dementia level care for up to 40 residents. There were 16 of a potential 17 residents in the secure dementia unit and 16 of 23 residents in the rest home area on the day of the audit. With the exception of one rest home level resident funded by ACC, all residents were under the ARRC contract. One resident residing in the rest home area has been assessed at hospital level care and the service has received dispensation for this resident. The service continues to be managed by an experienced nurse manager who has been in the role for eleven years, having worked previously at the service as a caregiver before completing nursing training. She is supported in her role by an administration/quality person and a clinical lead (senior caregiver). The nurse manager speaks regularly 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 exceeded eight hours of training relating to the management of a rest home. There is a 2016 business, quality and risk plan in place. The plan documents the mission and philosophy of the organisation and objectives for the year. It includes a review of the 2015 goals.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality	FA	Norfolk Lodge has an established quality and risk management system. The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards. Policies are current and staff are informed of updates and changes. The service has very well established and comprehensive monthly meetings documented. Key components of the quality management system are discussed at the quality meeting such as quality outcomes, audits, health and safety, restraint, complaints and infection control. Staff training is provided

improvement principles.		as part of the monthly meetings (link CI 1.2.7.5). Infection control and health and safety data such as accident/incidents are reviewed monthly, a report is documented each month which includes trends. This is reported to the nurse manager and quality meeting. Internal audits are completed according to the schedule. Corrective action plans are developed when service shortfalls are identified. There is a hazard management, health and safety and risk management programme in place. There are facility goals around health and safety and an up-to-date hazard register. Falls prevention strategies are in place and include reviewing the time and place of falls each month, with corrective action plans as needed.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	The service documents and analyses all incidents/accidents. Individual incident reports are completed for each incident/accident with immediate action noted. All incident forms reviewed documented follow up by a registered nurse including completion of neurological observations for all unwitnessed falls or falls with a possible head injury. All pressure injuries (previous) had been reported as incidents and are benchmarked. A monthly report of all incident and accidents is documented each month. The report includes a trend analysis as well as review of times and place for all falls. The service communicates this report through the quality meeting. Discussions with service management, confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	There are job descriptions available for all relevant positions that describe staff roles, responsibilities and accountabilities. The registered nurse (manager) has a current practising certificate. Five staff files were reviewed and included three caregivers, the activities coordinator and the lead carer (senior caregiver). All files included appropriate employment documentation and up-to-date performance appraisals and documentation. Competencies such as medication, hoist use, hand hygiene, restraint and health and safety were viewed on staff files. The service has an implemented orientation programme in place that provides new staff with relevant information for safe work practice including around caring for those with dementia. Staff interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. There is an annual education schedule that is being implemented and there is good attendance at staff training. There are 22 caregivers that work in the dementia unit and all have completed the required

		dementia standards. The service continues to exceed the required standard around training.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	Norfolk Lodge has a weekly roster in place which continues to provide 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, residents and family interviewed advised that sufficient staff are rostered on for each shift. All staff have been trained in first aid and CPR.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	There are policies and procedures in place for safe medicine management that meet legislative requirements. All clinical staff who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided. Staff were observed safely administering medications. The registered nurse and care staff interviewed were able to describe their role in regard to medicine administration. Standing orders are not used. There were no self-medicating residents on the day of audit. An electronic system for medication charting and recording of administration of medications is used. All ten medication charts reviewed identified that the GP had seen and reviewed the resident three monthly. Medications are delivered to the site by the pharmacy and on arrival are checked and signed in by the senior carer/duty leader. The service has facilities to safely store medications. The medication fridge temperature is monitored and temperatures are within an acceptable range.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	All meals at Norfolk Lodge are prepared and cooked on-site by qualified chefs and a kitchen hand, who have food safety certificates. There is a six weekly summer/winter menu which had been reviewed by a dietitian. All meals are plated in the kitchen with the meals for the dementia unit covered and transferred to the unit. The rest home dining area is adjacent to the kitchen. Dietary needs, including special diets, are known and catered for with individual likes and dislikes accommodated. Cultural and religious food preferences are met. Staff were observed assisting residents with their meals and drinks. Supplements are provided to residents with identified weight loss issues and the DHB dietitian is available on referral. Family surveys and interviews with residents allow for the opportunity for resident feedback on the meals and food services generally. Residents and family members interviewed were highly satisfied with the food and

		confirmed alternative food choices were offered for dislikes. Food storage and preparation met requirements including the fridge and freezer temperatures. End cooked food temperatures are recorded on each meal. The dishwasher is checked regularly by the chemical supplier. There is evidence that additional nutritious snacks are available over 24 hours in both areas. All food services staff under take training in food safety and hygiene and chemical safety.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	When a resident's condition alters, the manager initiates a review and if required, GP or specialist consultation. There was evidence that family members are notified of any changes to their relative's health including (but not limited to): accident/incidents, infections, health professional visits and changes in medications. The duty leaders and caregivers follow the care plan and report progress against the care plan each shift at handover. If external nursing or allied health advice is required, the manager or duty leader will initiate. If external medical advice is required, this will be actioned by the GPs. Staff have access to sufficient medical supplies (e.g. dressings). Sufficient continence products are available and resident files include a continence assessment and plan as part of the plan of care. Wound assessment, monitoring and wound management plans were in place for one wound being treated. There were no pressure injuries being treated on the day of audit. The RN has access to specialist nursing wound care management advice through the district health board. Appropriate pressure injury interventions were documented in the care plans of residents identified as high risk of pressure injury.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	The service has three qualified diversional therapists working a total of 60 hours per week. A fourth staff member is also a qualified diversional therapist. An activity assessment is completed on admission in consultation with the resident/family (as appropriate) and an activity plan is written. The plan is reviewed six monthly in conjunction with the RN. Files sampled evidenced that reviews occurred six monthly. There is a wide range of activities offered that reflect the resident needs and participation is voluntary. One on one activities occur for residents who are unable or choose not to be involved in group activities. Activity participation sheets are maintained. The service receives feedback and suggestions for the programme through surveys and one on one feedback from residents (as appropriate) and families. The service has two vans (one with a hoist) in order to enable residents to regularly go on outings and to community events.

		There is a separate activity programme held in the dementia unit. The individual activities observed were appropriate for older people with dementia. There are resources available for care staff to use for one on one time with the resident over the 24-hour period. Residents stated they are satisfied with the activities provided.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	The long-term care plan is evaluated at least six monthly or earlier if there is a change in health status. Evaluations are documented and changes in health status are updated on the care plan. Six monthly reassessments have been completed using the interRAI LTCF for all residents and for those who have had a significant change in health status. Short-term care plans are evaluated and resolved or added to the long-term care plan if the problem is ongoing. Where progress is different from expected, the service responds by initiating changes to the care plan.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	The service facilitates access with other medical and non-medical services. Referral documentation is maintained on resident files. The manager initiates referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs. Referrals and options for care were discussed with the family, as evidenced in clinical notes. A reviewed resident record provided an example of where a resident's condition had changed and the resident was reassessed. One resident in the rest home had been assessed as hospital level and documentation from Taranaki District Health Board providing dispensation to retain the resident on-site at hospital level had been reviewed and remained valid.
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 has a current building warrant of fitness that expires on 3 May 2017.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and	FA	Norfolk Lodge has an established infection control programme. The infection control programme, its content and detail is appropriate for the size, complexity and degree of risk associated with the service. It is linked to the incident reporting system. The manager (RN) is the designated infection control nurse with support from the quality team. Audits have been conducted and include hand hygiene and infection

methods that have been specified in the infection control programme.		control practices. Data on infections is collected and analysed. Feedback is given to staff at the monthly meeting and ways of improving are discussed. Information is graphed and available to staff.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0, including enablers should be voluntary. Restraint minimisation is overseen by a restraint coordinator, who is the nurse manager. There is one resident requiring bedrails in the rest home. There were no enablers in use. The restraint standards are being implemented, which is reviewed through internal audits and facility meetings. Training and competencies have been completed by staff, where appropriate.

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.

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	CI	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.	One of the objectives of Norfolk Lodge is to have more highly qualified staff. Lodge continues to support their Māori and other 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. The organisation provides resources for staff education including 12 hours per week divided over two staff, both of who are both 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 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. The service has acknowledged the difficulty for some staff with transportation and provides a transport service to enable staff to access training.

End of the report.