# John Wade Consulting Limited - Norfolk Court Rest Home

## Introduction

This report records the results of a Provisional 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 Audit (NZ) 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** John Wade Consulting Limited

**Premises audited:** Norfolk Court Rest Home

**Services audited:** Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care

**Dates of audit:** Start date: 14 March 2017 End date: 15 March 2017

**Proposed changes to current services (if any):** The rest home is being sold. The prospective provider does not intend to change the current services provided.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 53

# 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.

## General overview of the audit

Norfolk Court Rest home is undergoing a change in ownership. The rest home currently provides rest home, hospital and dementia level care for up to 63 residents.

This provisional audit was conducted to assess how well prepared the prospective provider is to own/manage the rest home, and the extent to which the existing provider is conforming to requirements prior to the change in ownership.

The audit included interviews with residents, staff, family members, general practitioner (GP) and the prospective provider. Policies, procedures, records and documents were sampled. Observations were included. Specific requests from the district health board were followed up.

There are six areas where improvements are required to achieve full compliance. These have been assessed as a moderate risk and relate to maintaining the currency of policies and procedures, updating first aid certificates, completing performance appraisals, meeting time frames for service provision and maintaining a safe environment.

## Consumer rights

Documented procedures, interviews with residents, family members and staff, together with observation confirm that residents’ rights are understood and met in everyday practice. Communication channels are clearly defined and interviews and observation confirm communication is effective. Information on rights and services is provided in an appropriate manner.

Residents are free from discrimination and have access to advocacy services. Reports or allegations from residents regarding concerns are followed up and remedied in a timely and appropriate manner. Resident meetings occur and the manager has an open-door policy.

Informed consent requirements are clearly defined and residents and staff member interviews confirm choice is given and informed consent is facilitated. Links with community resources are supported and facilitated. Visitors are free to come and go as requested by the resident.

Resident interviews confirm understanding of their right to make complaints if necessary. A complaints register is maintained. Complaints are used as an opportunity to improve services.

The prospective provider is aware of their obligations regarding resident rights.

## Organisational management

Norfolk Court is currently privately owned and governed by two directors, one of whom is the chief executive officer (CEO). The purpose, values, scope, direction and goals of the organisation are developed by the facility manager and the directors. Day to day operations are the responsibility of the facility manager who is an experienced registered nurse. The manager is suitably experienced and qualified.

The prospective provider confirmed that the required preparation, notification and pre purchase activities have been completed.

The organisation has a quality and risk management system in place that is monitored and reviewed to generate improvements in practice and service delivery. The required policies, procedures and work instructions are in place and accessible. Key quality goals are defined and achievement towards these goals are reported and communicated during regular staff meetings. The organisation implements an internal monitoring programme. Corrective actions are developed where a short fall is identified. Risks are identified and managed accordingly. The risk management and adverse event reporting system is managed well.

Human resource management and employment policies are in place. There is a system for validating professional qualifications. Staffing is appropriate to meet the needs of residents over the 24 hours with experienced advice and assistance available. There is an in-service education programme that meets requirements and covers relevant aspects of care and support. The prospective provider intends to maintain the current staffing level.

Resident information is securely maintained, integrated, current and up to date.

## Continuum of service delivery

There are documented admission processes that require potential residents to be assessed as rest home, dementia or hospital level of care.

Nursing staff are responsible for the development of care plans. There is a process for the assessment, evaluation and review of care plans. Care plan interventions are sufficiently detailed to support the resident’s needs and meet expected goals. There are planned activities that are meaningful to the residents, develop and maintain resident’s strengths skills, resources and interests.

The medication management system complies with legislation and best practice guidelines for aged care. Medications are administered by nursing staff with current medication competencies. Residents who are self-administering medications are assessed as competent.

Nutritional needs are provided in line with nutritional guidelines and residents with special dietary needs are catered for. The kitchen was observed to be clean, tidy and meets food safety requirements.

## Safe and appropriate environment

The facility is appropriate to the needs of the residents and is purpose built. All equipment was observed to be in good working order. Well-furnished lounges, dining and external areas are accessible to all residents. The dementia unit is secure and has a well-equipped secure outdoor area. The facility has plenty of natural light and is maintained at a comfortable temperature. Bedroom areas are sufficient in size to allow for personal possessions and to accommodate mobility aids, equipment and staff caring for the resident. Toilet, shower and bathing facilities are sufficiently equipped. Applicable building and fire regulations are met.

Cleaning and laundry services meet infection control requirements and are of a good standard. Collection, storage and disposal of waste is in accord with infection control principles. Staff comply with safe waste and hazardous substances processes.

Appropriate processes are in place to maintain the safety and security of residents over the 24 hours and during an emergency. The organisation has appropriate stores and equipment in the event of a civil defence emergency or a pandemic.

The prospective provider has no intention to make significant changes to the facility, other than on going necessary maintenance and possible refurbishments as required.

## Restraint minimisation and safe practice

There are clear and detailed documented guidelines on the use of restraints, enablers and challenging behaviours. There were seven residents using restraint and two enablers used at the time of the audit. Staff interviewed demonstrated a good understanding of restraint and enabler use and receive ongoing restraint education. The dementia area is secure, however visitors are able to come and go as they please.

## Infection prevention and control

Infection control management systems are in place to minimise the risk of infection to residents, visitors and other service providers. There is an infection control coordinator. Policies and procedures are current and education and training is provided. Infection data is collated monthly, analysed and reported. The type of infection surveillance undertaken is appropriate to the size and type of the service. Results of the surveillance are acted upon, evaluated and reported.

## 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 | 46 | 0 | 0 | 4 | 0 | 0 |
| **Criteria** | 0 | 94 | 0 | 0 | 6 | 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

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| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | Policies and procedures on resident rights are documented and included in the information given to residents on entry. Residents and family members interviewed reported they were well treated and expressed no concerns regarding their rights.  All staff receive training on resident rights and the Code of Health and Disability Services Consumers' Rights (the Code) during orientation. Additional training on the Code (and advocacy services) is provided. Staff interviewed were able to verbalise how they incorporate the principles of the Code into every day practice and the general practitioner (GP) reported no concerns regarding resident rights. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Residents and their families are provided with the information they need to make informed choices and informed consent. The required consents were sighted in resident records sampled. Records of enduring power of attorney are maintained and activated for those who have been assessed by their GP as not competent. Consents include treatment options, sharing of information, photos, treatment, restraint approval and resuscitation options. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Information about the right to advocacy and contact details for local services is included in the information pack given and explained to residents and families on admission. Consumer rights training including the right to advocacy / support is provided for staff. The Nationwide Advocacy Services pamphlet is displayed at the entrance to the facility. The complaints process is cross-referenced to advocacy services. Residents interviewed are able to identify who they would talk to if they needed additional support and are aware of their right to access independent advocacy services. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | There is an open visiting policy in place. Visitors were observed to be made welcome. Interviews with residents and family members confirm that they may entertain their visitors in the main lounge, outdoor seating areas or in the privacy of their own rooms. Links with community resources are supported and facilitated. Families are encouraged to take their resident out if able. Van trips go into the community and management/ staff ensure that all residents have an opportunity to go on outing regularly. Some rest home residents access the community independently. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaints policy and procedure meet Right 10 of the Code. The complaints process is easily accessible to residents. Staff interviewed are well versed in the complaints process and staff support residents and families to voice their concerns.  A complaints register is maintained. There have been five formal complaints in the last year. Records confirmed that these have been addressed to the satisfaction of the complainant. The most recent complaint was made anonymously to the DHB. The complaint related to staff numbers. A full investigation has been conducted which resulted in the return of additional short shifts for care givers in the dementia area. Records of complaints confirmed that the required actions were investigation was conducted and followed up. Complaints are discussed in detail at quality meetings. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | The Code and information on advocacy services is provided on admission and is displayed throughout the facility. Residents interviewed confirmed that information on their rights is provided, as are opportunities to discuss concerns. Signed resident admission agreements were sighted in residents’ files sampled. The agreement includes the required information including liability of payment items.  The prospective provider was interviewed and is aware of their responsibilities under the Code. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | There are documented policies and procedures regarding the privacy of residents, ensuring the protection of personal property and maintaining the confidentiality of residents’ related information. Residents are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. All bedrooms are single occupancy and staff were observed working with residents in a private and respectful manner. Where able and safe, resident’s independence is promoted.  Policies and procedures on abuse and neglect include definitions and reporting requirements. All staff receive training on the identification and reporting of concerns. There were no complaints or adverse events regarding alleged abuse or neglect. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  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. | FA | There are currently five residents who identify as Maori, as do a number of staff. There is a documented Maori health plan which is inclusive of the Maori model of health and a commitment to the principles of the Treaty of Waitangi. Potential barriers to Maori residents who may wish to access the service are identified and strategies to address these are detailed. This includes the involvement of family/whanau and consultation from tangata whenua if required. The facility manager is of Maori decent and discusses whakawhanaungatanga with all perspective residents. The facility manager has also previously worked for an Iwi provider and maintains contacts in the community. Staff receive cultural training and the assessment and care planning process makes provision for cultural needs if required. An introduction to cultural safety is also included in orientation of staff. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | Resident’s receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. Cultural assessment is undertaken as part of the admission process conducted by the RNs. This was sighted in resident’s files sampled. Some residents attend church gatherings and services of their choice which was sighted as part of their planned activities. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Policies, procedures and guidelines, staff and resident interviews and observations confirm that residents are protected from discrimination, coercion, harassment of exploitation. Any form of discrimination is not acceptable within the organisation. Staff receive adequate training on discrimination, professional boundaries, code of conduct and activities which constitute misconduct. The code of conduct and professional boundaries are included in individual job descriptions and both are monitored and maintained through effective communication processes, completion of the required staff performance appraisals and an accessible complaints process. The adverse event reporting system ensures any breach in boundaries is identified, and there is evidence that this process is effectively implemented resulting in staff dismissal where indicated. Residents and family members interviewed confirm they are treated with dignity and respect and are not subject to discrimination. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | Residents receive services of an appropriate standard. The required clinical policies and procedures are developed in line with best practice and are current. There is adequate equipment that can be used by RNs and caregivers to address the residents care needs. For example, hoists, nebulisers, oxygen concentrators and other medical devices.  The organisation is a member of the New Zealand Aged Care Association (NZACA). The CEO attends NZACA meetings. The facility manager receives peer support from the DHB liaison nurse and obtains regular updates from an independent aged care advisor. Education and training is provided in order to maintain best practice. Caregivers are required to commence aged care national training within six months of employment and external training is accessed as available. Job descriptions and professional boundaries for RNs and caregivers are documented. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents speak English and the services of an interpreter can be accessed if required. Incidents and complaints are managed in an open manner and there is clear evidence of family contact in incident records and residents' progress notes. All staff are identifiable and wear name badges and a uniform. Resident meetings occur and records confirm open feedback. Residents and family members interviewed state they have the opportunity to talk to facility manager or staff and are able to request changes if needed.  Residents receive adequate information regarding the services they will be provided. All residents (or family) sign a resident agreement which outlines subsidies and services that are provided. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | At the time of the audit ownership and governance had not changed since the last audit. Top management includes two owner/directors and the facility manager. The current owners/directors have owned the rest home for more than 20 years. The facility manager is an experienced registered nurse and has been in the role since 2013.  John Wade Consulting is the company that has been established for the purpose of ownership/governance and management of the rest home (hereafter referred to as the prospective provider). There are three directors for the land and buildings part of the business, and two directors for the rest home business. A draft organisational structure has been developed which includes the two rest home business directors working on site in management and administrative roles.  One of the prospective providers has a background in nursing and management and has work experience in mental health, addictions, disability and aged care sector. A list of previous work experience was provided. An annual practising certificate has not been maintained, however the role of a designated clinical lead/manager will remain following the purchase.  The prospective provider has commenced strategic planning and has a documented proposal for the purchase and operations of the rest home. This includes an analysis of demographics, the current market, strengths, weaknesses, future direction and vision, including the philosophy. Critical success factors are identified and include maintaining high quality standards. There is a predetermined lead in time with the current owner providing the new owners with an agreed 28 day handover. The proposed date for finalising the sale and purchase agreement is 31 March 2017.  The prospective provider has no plans change to the current service. The rest home is certified to provide 63 residential beds. An additional audit has recently been undertaken to gain approval to reconfigure the number of rest home and hospital level care beds. The increase in hospital level beds was approved by the Ministry of Health on 16 March 2017. The rest home has now been approved to provide 35 dual purpose beds and 13 rest home level beds. The 15 bed dementia unit remains the same.  There were 53 residents on the day of the audit (13 dementia, 20 hospital and 20 rest home). Previous dispensations for two additional hospital level residents are no longer required with the approved reconfiguration. |
| Standard 1.2.2: Service Management  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. | FA | The facility manager has two staff that are able for perform duties during a temporary absence. This includes the next most senior registered nurse and one of the administrators. The current owner/manager has previously been available if required.  The prospective provider intends to manage the facility and will be on site business hours, five days per week. The role of a clinical lead/manager will be maintained, however there may be some minor restructuring of the clinical and administrative team in terms of reporting, accountabilities, responsibilities and authorities. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Moderate | There is a current documented quality and risk management system which is compliant to requirements of this standard and the contract with the DHB. Policies and procedures are required to be reviewed periodically or when a change in internal processes, best practice or legislation occurs, however not all documents have been reviewed as required. Obsolete documents are removed from the system. Clinical policies are reviewed by the clinicians.  Organisational performance is monitored. A quality plan is documented in measureable terms. The facility manager maintains a comprehensive schedule of all monitoring and performance requirements. This ensures actions are completed as required, or rescheduled in the event of cancellation due to other priorities. Quality activities are implemented and a range of quality data is gathered. This includes satisfaction surveys, internal audits, data on outputs and outcomes, collated adverse events, health and safety monitoring and corrective action planning. All data is discussed at monthly quality meetings. This includes an analysis on trends and suggested improvements.  Organisational risk is documented and frequently discussed with the CEO and at quality meetings. There is a current hazard identification and management system.  The prospective provider reports that the current quality and risk management system, including policies, procedures and quality plan (and related activities) will remain in place following the purchase as they become more familiar with the system. Current quality activities will continue to be implemented as required. |
| 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 | There is a documented process for the management of incidents and accidents. All staff have access to the incident and accident reporting process. Incident and accident forms are forwarded to the facility manager for closure and collation. Incidents and accidents are monitored by type, time and location. This provides sufficient data to identify trends and develop targeted corrective actions. Data on all incidents and accidents is reported at quality meetings.  Records of incident and accident reports were sampled. There was evidence of the required immediate actions, assessment, observations and preventative actions. It was noted that one resident care plans had not been updated following an event. This has been documented in standard 1.3.3.3.  Essential notifications were made as required. Serious Assessment Codes (SAC) are used for reporting pressure injuries to the DHB. There is evidence that the police, Ministry of Health, DHB, GP and family are notified as required. |
| 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. | PA Moderate | There are written policies and procedures in relation to human resource management which comply with current good employment practice. Staff files sampled confirmed that the skills and knowledge required for each position is documented in job descriptions. Job descriptions outline accountability, responsibilities and authority. There is evidence of the required recruitment screening and there is a system for the validation of professional qualifications for both employed and external health professionals. All new staff receive an orientation to the facility and to their respective role. The orientation programme includes the essential components of service delivery, including emergency procedures. A buddy programme is implemented and records of buddy training are maintained.  There is a planned programme of on-going education. The programme has been maintained and resources are well documented. A training planner is developed annually and meets the contract requirements in terms of topics to be covered and hours to be maintained. Individual training records are maintained, however attendance at mandatory in-service training has been fewer than expected.  Care givers are required to commence the national certificate in working in aged care within six months of commencement. Staff working in the dementia unit have either commenced, or have completed the required dementia related qualifications. Medication competencies are maintained for those who require them.  A further two improvements are required to ensure full compliance with this standard, or the DHB contract. First aid certificates have not been maintained for those who are required to have them and annual performance appraisals have not been conducted annually as required. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The facility manager has recently received guidance from a DHB representative as part of ensuring that staffing requirements are maintained (refer standard 1.1.13). There are currently eight registered nurses employed (one is currently on leave) plus the facility manager. There is one nurse per shift for the whole facility plus the clinical team leader business hours Monday to Friday. On the weekends there is one RN on with another one in the building (completing care plans). This is consistent with contract requirements and the employee assistance programme (EAP) recommendation for the required nursing hours for rest home and hospital level care.  The number of caregivers rostered has recently increased. There are now six care givers rostered in the morning, five in the afternoon and two on during the night. In the event of a temporary absence from the roster, cover is maintained to meet the minimum requirements of the ARC contract. This is confirmed in rosters sampled.  It is noted that there has been some difficulty in recruiting and retaining caregiver staff. RN’s have a responsibility, and are given the authority, to ensure adequate shift coverage in the event of staff absence occurring after hours.  The prospective provider is aware of the requirements for maintaining a clinical lead/manager role and has no intention of changing the current roster. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | Residents' demographic information is documented on entry. The admission assessment includes verification and documentation of individual resident information. Review of residents’ records indicate that they include reports from all health professionals. Daily progress notes are maintained and records are integrated in the one file. Entries are legible, dated, signed and designated. Records of current and previous residents are securely maintained. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | The entry to service policy has all the required aspects on the management of enquiries and entry. Norfolk Court Rest Home’s welcome pack contains all the information about entry to the service. Assessment and entry screening processes are documented and clearly communicated to residents, family/whanau of choice where appropriate, local communities and referral agencies.  Admission requirements are conducted within the required time frames and are signed on entry, as sighted in the files sampled. The admission agreement clearly outlines services provided as part of the agreement to entry. Residents and family/whanau interviewed confirmed that they received sufficient information regarding the services at the facility. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | The standard transfer form notification from the DHB is utilised when residents are required to be transferred to the public hospital or another service. Residents and their families are involved in all exit or discharges to and from the service and sufficient evidence in the resident’s records to confirm this was sighted. |
| 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 | The medicines management system complies with legislation, protocols and guidelines. There is a documented policy in the management of the medication system. All medications files sampled confirmed that they are reviewed as required and discontinued medications are signed and dated by the GP. Allergies are documented, identification photos are present and three monthly reviews are completed. Medication charts are legibly written. The nursing staff were observed administering medication correctly in their respective departments. Medication reconciliation is conducted by the RNs when a resident is transferred back to service.  The service uses pharmacy pre-packed packs that are checked by the RNs on delivery. The controlled drug register is current and correct. Weekly, monthly and six monthly stock takes are conducted and all medications are stored appropriately. There were two residents self-administering medication at the time of the audit and were assessed as competent. There is a policy and procedure for self-administration of medication if required.  An annual medication competency is completed for all staff administering medications and medication training records were sighted. |
| 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 | Meals are prepared on site and served in the respective dining areas. The menu has been reviewed by a dietitian. The kitchen staff have current food handling certificates. Diets are modified as required and the cook confirmed awareness of the dietary needs of residents. An assessment on nutritional needs is developed on admission which identifies dietary requirements, likes and dislikes. Supplements are provided to residents with identified weight loss issues. All residents, including those in the dementia area, have access to foods and fluids over the 24 hour period.  The kitchen and pantry were observed to be clean, tidy and stocked. Labels and dates are on all containers and records of temperature monitoring of food, fridges, freezers and chiller are maintained. Regular cleaning is undertaken and all services comply with current legislation and guidelines. All decanted food had records of use by dates recorded on the containers and no expired items were sighted.  The residents and family/whanau interviewed indicated satisfaction with the food service. The food audit conducted in February 2017 indicated that residents/family are happy with the meals provided and any other adjustment made accordingly. |
| Standard 1.3.2: Declining Referral/Entry To Services  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. | FA | The facility manager reported that whenever a consumer is declined entry family/whanau are informed of the reason for this and other options or alternative services available. The consumer is referred to the referral agency to ensure that the consumer will be admitted to the appropriate service provider |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Initial assessments are completed on admission while care plans are completed within three weeks. Assessments and care plans are detailed and include input from the family/whanau and other health team members as appropriate. The nursing staff utilise standardised risk assessment tools on admission. In interviews, the family/whanau expressed satisfaction with the support provided. An improvement regarding the timeliness of completing interRAI assessments is documented in standard 1.3.3. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | There are documented processes in ensuring that long term support care plans are resident focussed, integrated and provide continuity of service delivery. The assessed information is used to generate long term support care plans and short term care plans or nurse’s specific instructions to care givers for short term problems. Goals are appropriate, congruent and achievable and interventions are detailed to address the desired goals/outcomes identified during the assessment process. Additional needs and requirements as identified by allied health providers are included in care plans where required. The family/whanau interviewed confirmed care delivery and support is consistent with their expectations and plan of care. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | The documented interventions in short term care plans or nurse’s specific instructions to care givers and long term support care plans are sufficient to address the residents assessed needs and desired goals/outcomes. Significant changes are reported in a timely manner and prescribed orders carried out satisfactorily as confirmed by the GP. Progress notes are completed on every shift. Adequate clinical supplies were observed and the staff confirmed they have access to enough supplies. Residents and family/whanau members interviewed reported satisfaction with the care and support they are receiving. |
| 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 planned activities are meaningful to the residents’ needs and abilities. The activities programme covers physical, social, recreational, spiritual, intellectual, emotional and cultural needs of the residents. The temporary activities coordinator reported that they ascertain the resident’s response and interest during activities and modify activities accordingly. The activities are modified as per capability and cognitive abilities of the residents. The activities coordinator develops an activity planner which is posted on the notice boards and residents informed by word of mouth. Residents’ files have a documented activity plan that reflects their preferred activities of choice. An individual assessment and 24-hour dementia diversional care plan was sighted in all care plans in the dementia unit. Over the course of the audit residents were observed engaging in a variety of activities. The residents and family/whanau reported general satisfaction with the level and variety of activities provided. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Residents’ long term support care plans, interRAI assessments and activity plans are evaluated at least six monthly. Family/whanau and staff input is sought in all aspects of care. The evaluations record how the resident is progressing towards meeting their goals and responses to interventions. Short term care plans are developed when needed and signed dated and closed out when the short term problem has resolved. The required evaluations were sighted in resident records sampled. |
| 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 | There is a documented process for the management of all referrals. The service utilise a standard referral form when referring residents to other service providers. The GP confirmed that processes are in place to ensure that all referrals are followed up accordingly. Resident and family are kept informed of the referrals made by the service. All referrals are facilitated by the GP, manager and registered nurses. An improvement has been documented in standard 1.3.3 regarding the timeliness of referrals for one resident who had an ongoing problem with non-healing ulcers. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | There are documented policies and procedures for the management waste and hazardous substances. Personal protective equipment is available throughout the facility. Domestic waste disposal meets council requirements and is removed from site as required. Infection control policies include the use of single use items. Chemicals and used products are securely stored or disposed of. All staff receive training on the use of personal protective equipment (PPE) and the management of waste and hazardous substances. Hazardous substances are included in the hazard identification process and the storage of dangerous goods is included in the risk register. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | PA Moderate | The building is separated into three distinct areas. The secure dementia unit (the ‘Haven’), and two wings which can accommodate residents requiring either rest home or hospital level care. The outdoor area used by the residents in the dementia unit is secure and safe. There is adequate parking. There is a current building warrant of fitness and the prospective provider has had a building report conducted.  Electrical testing is conducted. Medical equipment is calibrated. Furniture is provided and maintained in good order. There is a maintenance schedule, however the schedule has not been maintained, and some areas were identified by the auditor as requiring attention to maintain infection control requirements and safety for the residents. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  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. | FA | There are sufficient numbers of toilets, showers and bathing facilities, including two spa baths. There is a combination of shared bathrooms and private ensuites. All rooms have a hand basin. Hot water is maintained at a consistent temperature which is checked monthly. Records of temperatures are maintained and any variations are reported to management. There are two spa baths, one of which can be lowered to accommodate safe entry. Residents and family members interviewed voiced no concerns regarding the toilet/bathing facilities, including maintaining privacy. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | All resident rooms are currently single occupancy; however there are five rest home rooms which could be used as double rooms if required. All resident rooms are sufficient in size for personal items and equipment. Each room has a hand basin, cupboard, arm chair and suitable bed to support care needs. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | All areas have adequate and well-furnished lounge and dining areas. These areas are well utilised and sufficiently sized, however it was noted that the lounge in the dementia area can appear over crowded when occupancy exceeds 13 residents. This is being monitored by the clinical manager. Private rooms can be used as low stimulus areas in the dementia unit. Residents and family members interviewed voiced no concerns regarding the communal and dining areas. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | Cleaning and laundry services meet infection control requirements and are of an appropriate standard. The laundry has good separation of clean and dirty areas. All laundry is done on site and there are designated laundry staff.  Day to day cleaning is completed by designated cleaners. Staff are trained at orientation in the use of equipment and chemicals. Documented guidelines are available and duty schedules for cleaning and laundry are provided for both day and night duties.  Cleaning and laundry hazards are documented. Material data safety sheet are displayed. Cleanliness and laundry standards are monitored through annual internal audits and resident feedback. The facility is observed to be clean on the days of the audit. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | Appropriate processes are in place to maintain the safety and security of residents over the 24 hours and during an emergency. The fire service has approved the current evacuation plan records of biannual fire drills are sighted.  The building is separated by smoke stop doors and fire door. A smoke alarm system and sprinkler system is in place and fire extinguishers are sighted. Evacuations procedures are displayed throughout.  An emergency management plan is documented and there is a range procedures for the management of emergencies. Outbreak management and pandemic planning is cross referenced to the Ministry of Health guidelines. Adequate civil defence supplies are available and include the required equipment and stores. There is adequate food and water supplied in the event of an emergency. The building has emergency lighting in the event of a power failure and there is a BBQ and one stove in the kitchen is gas.  All bed spaces, bathroom and toilets throughout the facility have a nurse call bell and these were seen to be within easy reach of the resident. The location of the call shows above the door of the resident's room. There is a security code on the door to the dementia unit and the section is fully fenced. Staff conduct a round in the evenings to ensure all doors and windows are secure.  All staff receive training in the management of emergencies which is included in orientation and on the in service schedule. Refer to standard 1.2.7 regarding first aid training. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | The facility has plenty of natural light. All rooms have at least one good sized window for natural light. There is plenty of natural ventilation and sunlight. Interview with residents indicate that the internal environment is maintained at a comfortable temperature. There are no concerns voiced by residents, or family regarding the temperature of the facility. There is a designated smoking area outside. |
| Standard 3.1: Infection control management  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. | FA | The organisation provides an environment that minimises the risk of infection to residents, staff and visitors by implementing an appropriate infection prevention and control programme. The facility manager is the infection control coordinator (ICC) and has access to external specialist advice from the GPs’ and district health board infection control specialists when required. The infection control programme at Norfolk Court Rest Home allows for a systematic, coordinated and continuous approach.  The infection control programme is reviewed annually and is incorporated in the monthly meetings and review of the education programme. Staff are made aware of new infections through handovers on each shift and progress notes. The infection control programme is appropriate for the size and complexity of the service. Infection control practices are guided by infection control policies and procedures. Interview conducted with the ICC indicated that all infections are monitored through a surveillance system in accordance with the infection control programme. There are processes in place to isolate infectious residents when required.  A documented job description for the ICC including role and responsibilities is in place. Hand sanitisers and gels are available for staff and visitors to use. The service had a scabies outbreak in September 2016 which was managed effectively and according to documented and infection control guidelines. Staff interviewed demonstrated an understanding of the infection prevention and control programme. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The ICC is responsible for implementing the infection control programme and indicated adequate human, physical, and information resources to implement the infection control programme. Infection control reports are discussed at the management and monthly staff meetings, or when necessary. The ICC has access to all relevant resident data to undertake surveillance, internal audits and investigations respectively. The infection control coordinator (ICC) is a member of the New Zealand Nurses Organisation (NZNO) infection control forum. |
| Standard 3.3: Policies and procedures  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. | FA | There are documented policies and procedures in place and reflect current best practice. Staff were observed to be following the infection control standards which are according to relevant legislation and current good practice. Staff demonstrated knowledge on the requirements of standard precautions and able to locate policies and procedures. The ICC is responsible for monitoring ensuring policies and procedures are current. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The ICC is a registered nurse and provides staff with annual infection control education. Training is conducted by the ICC,staff records of attendance are maintained and were sighted. The training education information pack is detailed and meets required legislative and current regulations. External contact resources included GP, laboratories and local district health board. Infection control is part of the orientation programme and all staff are required to complete a hand washing pledge. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | The infection surveillance programme is appropriate for the size and complexity of the organisation. Infection data is collected, monitored and reviewed monthly. The data is collated and analysed to identify any significant trends or common possible causative factors. All results of surveillance and specific recommendations are to assist in achieving infection reduction and prevention outcomes. These are acted upon, evaluated and reported to relevant personnel and management in a timely manner. Staff interviewed reported that they are informed of infection rates at monthly staff meetings and through compiled reports. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | Policies and procedures regarding the use of restraints and enablers provide consistent definitions which meet the requirements of this standard. Management and staff aim to minimise the use of restraint through completing risk assessments, use of call bells and equipment, staff training and education and restraint/enabler reviews. An updated restraint and enabler register was sighted and staff interviewed understood the difference between a restraint and enabler. |
| 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 | The facility manager is the designated restraint coordinator and is responsible for education of staff ensuring the restraint process is followed according to policy and procedure. The roles and responsibilities of the restraint coordinator are clearly defined and there are clear lines of accountability use. There is an approval process as part of the restraint minimisation policies and procedures that is applicable to the service and accessible to staff to read. Restraint authorisation is in consultation with resident, family/whanau, restraint coordinator and GP. The approval process ensures the environment is appropriate and safe. Restraint use is discussed in management and staff meetings.  Approved equipment which can be used as a restraint includes: bedrails; three-point harness; fallout chairs and low beds and. There are currently seven residents on restraint and two using enablers for safety and comfort. The family and residents are fully informed about the restraint process and risks involved.  All residents admitted to the dementia area have been assessed as requiring secure dementia level care. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | The restraint coordinator completes restraint assessment forms for residents who are assessed as requiring a restraint. There is evidence that risk factors are identified in the assessments and the purpose of the chosen restraint is clearly documented. The implementation of restraint for the resident is linked to the care plan. Interviewed staff members demonstrated understanding in maintaining culturally safe practice. Consent for the use of restraint is provided by the GP, restraint coordinator and family/whanau. Risk minimisation was documented in the care plans of residents and restraint use evaluated regularly. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | The long term support care plans have the required risk management plans and interventions to ensure the resident’s safety while using a restraint. The restraint monitoring and observation process is included in the restraint policy. The required monitoring was evident in residents’ records sampled. Restraint use is reviewed at least three monthly and six monthly and as part of restraint register reviews. This is conducted to assess whether or not the restraint continues to be the best option. Staff interviewed demonstrated understanding about restraints and strategies to promote safe practice. There were no restraint related injuries reported. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | Regular reviews are conducted on residents using restraint and this was evident in the records sampled. The GP confirmed involvement in the restraint review process. Reviews included: discussions on alternative options; care plans; least amount of time and impact on the resident; adequate support; sufficient monitoring and any change required. Interviewed staff and family/whanau confirmed involvement in the evaluation of restraint use. The evaluation forms included the effectiveness of the restraint in use and the risk management plans documentation in the long term support care plans. Evaluations time frames are determined by the risk levels. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | The service has demonstrated monitoring and quality review on the use of restraint. Restraint updates are included in the monthly staff and periodic quality control meetings. Individual approved restraints are reviewed three to six monthly through a restraint meeting and as part of the facility approval team review with family/whanau involvement. Meeting minutes confirmed discussions on restraint are being conducted and included a quality review of restraint use. The facility manager reported that assessments and monitoring are appropriate, as confirmed through internal audits. Policies and procedures are up to date and an annual review of restraint use was conducted. |

# Specific results for criterion where corrective actions are required

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

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

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

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.3.3  The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy. | PA Moderate | It is reported that the scheduled review of policies and procedures keeps getting rescheduled due to more urgent work. This has been identified to the CEO and additional resources requested. The health and safety policy has not been updated to reflect the changes in Work Safe legislation. It is noted that the review of policies and procedures was prioritised and all clinical policies have been reviewed to ensure they meet current good practice, Ministry of Health initiatives and current legislation. | Not all policies and procedures have been reviewed, or updated, as required. | Review policies and procedures as required.  180 days |
| Criterion 1.2.7.3  The appointment of appropriate service providers to safely meet the needs of consumers. | PA Moderate | The organisation requires all registered nurses to have a current first aid certificate. At the time of the audit, all first aid certificates had expired. It is noted that this has been identified and is being scheduled. | First aid certificates have expired. | Obtain current first aid certificates for those who are required to have them  30 days |
| 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. | PA Moderate | Not all performance appraisals have been completed annually as required. The facility manager has not had a formal performance appraisal since 2013. The delay is completing staff performance appraisals has been identified and there is a plan for completing.  In service education includes the mandatory training topics as required. Records of in-service training are sampled and confirmed low attendance despite training being offered frequently and twice on the same day. | Annual performance appraisals have not been conducted as required. Staff are not consistently attending mandatory training. | Complete performance appraisals as required. Ensure mandatory training is completed for all staff.  60 days |
| Criterion 1.3.3.3  Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer. | PA Moderate | All files sampled identified that initial care plans, long term care plans are completed within the required time frames, however not all interRAI assessments are completed within three weeks of admission; not all care plans have been updated or amended as clinically indicated by a change in the resident’s condition (refer standard 1.2.4); monthly observations are not being consistently documented as required and timely referral to a wound care specialist was not evident for one resident with a non-healing ulcer. | Not all expected timeframes for service provision have been met. | Complete each stage of service provision within the required timeframes.  90 days |
| Criterion 1.4.2.4  The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group. | PA Moderate | There are two toilet/shower areas which require minor maintenance to ensure resident safety and meet infection control requirements. These were identified to the prospective provider. Records of completing the required maintenance schedule have not been maintained since August 2016. | There is insufficient evidence that improvements to the facility have been maintained as required. | Complete the required improvements to the facility to ensure safety and infection control requirements.  60 days |
| Criterion 1.4.2.6  Consumers are provided with safe and accessible external areas that meet their needs. | PA Moderate | One of the external areas requires further work to ensure resident safety. This includes the deck and the external path outside the East wing. This was identified to the prospective provider. | Not all external areas have been maintained in a manner to ensure resident safety. | Fix the deck and path outside the East Wing.  60 days |

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

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

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

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

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End of the report.