

Norfolk Lodge Waitara Limited - Norfolk Lodge Rest Home

Introduction

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

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

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

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

The specifics of this audit included:

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: 15 January 2018 End date: 16 January 2018

Proposed changes to current services (if any):

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

General overview of the audit

Norfolk Lodge rest home is privately owned and provides rest home and dementia level care for up to 40 residents. On the day of the audit there were 32 residents.

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

The nurse manager is a registered nurse and has been in the role for 13 years. She is supported by a relieving registered nurse, administration manager, senior caregiver supervisor and a stable workforce. Residents and family interviewed were very complimentary of the services and care they receive.

One area for improvement was identified at this certification around neurological observations. The service has been awarded a continuous improvement rating around recognition of Māori.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		All standards applicable to this service fully attained with some standards exceeded.
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Norfolk Lodge provides care in a way that focuses on the individual resident. Cultural and spiritual assessment is undertaken on admission and during the review processes. Information about services provided is readily available to residents and families/whānau. The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) brochures are accessible to residents and their families. There is a policy to support individual rights. Care plans accommodate the choices of residents and/or their family. Complaints processes are implemented and managed in line with the Code. Residents are encouraged to maintain former links with the community. There are a number of community visitors to the home.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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The quality and risk management plan and quality and risk policies describe Norfolk Lodge's quality improvement processes. Policies and procedures are maintained by an external aged care consultant who ensures they align with current good practice and meet legislative requirements. Quality data is collated for infections, accident/incidents, concerns and complaints, internal audits and surveys. Quality data is discussed at meetings and is documented in minutes. The health and safety programme meet current legislative requirements. There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. There is an education programme covering relevant aspects of care and external training is supported. The staffing

policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care in the rest home and dementia unit.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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There is an admission package available prior to or on entry to the service. The registered nurse is responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family input. Care plans viewed demonstrate service integration and are reviewed at least six monthly. Resident files include medical notes by the contracted general practitioners and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Caregivers are responsible for the administration of medicines and complete education and medication competencies. Medication charts are reviewed three monthly by the GP.

The diversional therapists and recreational officer implement the activity programme to meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are regular outings, and celebrations.

All meals are cooked on-site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated. Snacks are available 24 hours.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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Chemicals are stored safely throughout the facility. Appropriate policies and product safety charts are available. The building holds a current warrant of fitness. There are no ensuites but there are sufficient communal showers/toilets. External areas are safe and well maintained with shade and seating available. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are monitored through the internal auditing system. Appropriate training, information and equipment for responding to emergencies are provided. There is an approved evacuation scheme and emergency supplies for at least three days. There is a trained first aider on duty 24 hours.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint, should this be required. There were no residents with restraint or enablers in use. Staff receive regular education and training on restraint minimisation. No restraint or enabler was in use on the day of audit.

Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The nurse manager/registered nurse is the infection control coordinator. The infection control coordinator has attended external education and coordinates education and training for staff. There is a suite of infection control policies and guidelines to support practice. Information obtained through surveillance is used to determine infection control activities and education needs within the facility. There have been no outbreaks.

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	1	43	0	0	1	0	0
Criteria	1	91	0	0	1	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
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) brochures are accessible to residents and their families. A policy relating to the Code is implemented and staff interviewed (one nurse manager, four caregivers [two rest home and two dementia care], one diversional therapist and one recreational officer) could describe how the Code is incorporated into the residents' daily activities of living. Staff receive training about the Code during their induction and as part of their two-yearly training plan.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>The service has in place a policy for informed consent. Completed resuscitation consent forms were evident on all resident files reviewed (three rest home including one younger person funded by ACC and two dementia care). General consent forms were evident on files reviewed. Discussions with staff confirmed that they are familiar with the requirements to obtain informed consent for entering rooms and personal care. Enduring power of attorney evidence is filed in the residents' charts.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>Health and Disability advocacy brochures are included in the information provided to new residents and their family/whānau during their entry to the service. Residents and family interviewed were aware of the role of advocacy services and their right to access support. The complaints process is linked to advocacy services. Staff receive regular education and training on the role of advocacy services. The visiting Reverend is available at any time as a resident advocate. Advocacy services are displayed in the main entrance.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>The service encourages their residents to maintain their relationships with friends/whānau and community groups. Residents may have visitors of their choice at any time. Assistance is provided by the diversional therapy team to ensure that the residents continue to participate in their chosen community group. There are links to the local marae, age concern, schools and a number of other community groups.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>There is a complaints policy to guide practice, which aligns with Right 10 of the Code. Complaints forms are visible and available at the main entrance of the facility. Residents and families interviewed are aware of the complaints process. A compliment and complaint register is maintained. The privacy officer (nurse manager) leads the investigation of any concerns/complaints in consultation with relevant staff for clinical concerns/complaints. Concerns/complaints are discussed at the monthly multidisciplinary (MDT) team meeting and evidenced in meeting minutes.</p> <p>There have been four verbal concerns and two written complaints to the service in 2017 that have been managed appropriately with a response, investigation and resolution within the required timeframe.</p> <p>There have been two complaints to the Health & Disability Commissioner in February 2017 and May 2017. A full investigation was completed with no further action for the February complaint and the May 2017 complaint was found to be unsubstantiated.</p> <p>An issues-based audit was conducted in July 2017. There is one corrective action remaining around RN attendance at interRAI skills booster, which is scheduled for February 2018.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>Details relating to the Code and the Health and Disability Advocacy Service are included in the resident information welcome pack that is provided to new residents and their families. The nurse manager discusses aspects of the Code with residents and their family on admission. Discussions relating to the Code are also held during the resident meetings. Five rest home residents and five family members (two rest home and three of dementia care residents) reported that the residents' rights were being upheld by the service.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>Care staff confirmed they promote the residents' independence by encouraging them to be as active as possible. Residents and families interviewed, and observations during the audit, confirmed that the residents' privacy is respected. All staff were observed to be respectful and caring towards the residents. The residents' personal belongings are used to decorate their rooms. Caregivers interviewed reported that they knock on bedroom doors prior to entering rooms and this was demonstrated on the day of audit. Guidelines on abuse and neglect are documented in policy. Staff receive education and training on abuse and neglect.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>CI</p>	<p>The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. The care staff interviewed reported that they value and encourage active participation and input from the family/whānau in the day-to-day care for any residents who identify with Māori. There were seven residents who identified with Māori on the day of audit. The service has access to a Māori health provider, Māori Reverend (interviewed), local iwi radio station, cultural groups and local Marae. Staff receive ongoing education on cultural awareness and many staff speak fluent Te Reo. Māori residents and relatives interviewed confirmed the service exceeded their expectations in meeting Māori culture, values and beliefs.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>The service identifies the residents' personal needs, culture, values and beliefs at the time of admission in consultation with the resident and family. Beliefs and values are incorporated into the residents' care plans in the five resident files reviewed. Residents and family/whānau interviewed confirmed they were involved in developing the resident's</p>

		plan of care, which included the identification of individual cultural and spiritual values and beliefs. Residents have access to spiritual visitors and advocates of their choice. Norfolk Lodge has a visiting Reverend for church services each week and who is readily available to counsel/support for residents, family and staff.
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	Professional boundaries are discussed with each new employee during their induction to the service. Professional boundaries are also described in job descriptions. Employees sign a code of confidentiality on appointment. Interviews with the care staff confirmed their understanding of professional boundaries including the boundaries of the caregivers' role and responsibilities. Professional boundaries are reconfirmed through education and training sessions, staff meetings and performance management.
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	Good practice is promoted and practiced around the provision of quality care and services provided at Norfolk Lodge. Policies have been developed by an aged care consultant in line with current accepted best practice. The content of policy and procedures are sufficiently detailed to allow effective implementation by staff. The service contracts a quality/risk consultant, 10 hours per week. A range of clinical indicator data are collected. Quality improvement plans (QIP) are developed where results do not meet expectations and feedback is reported to staff through staff meetings and staff newsletters. Norfolk Lodge was a runner-up at the 2017 aged care conference awards for the most qualified workforce with all 26 caregivers with level 3 or 4 Careerforce and three qualified diversional therapists. The care staff interviewed were knowledgeable about their role and the residents they were caring for. A registered nurse manager or relieving RN is available on duty or on-call 24 hours a day, seven days a week. Care staff confirmed on interview they feel supported and their contribution into resident care is valued. Residents and family interviewed were very satisfied with the care and services provided.
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	There is a policy to guide staff on the process around open disclosure. Residents and family interviewed confirmed the admission process and agreement was discussed with them. They were provided with adequate information on entry. The welcome pack includes specific

		<p>information for dementia care. The nurse manager operates an open-door policy and completes a daily round promoting open communication for residents, relatives and staff. Ten incident/accident forms reviewed for November 2017 identified family were notified following a resident incident. Family members interviewed confirm they are notified promptly of any incidents/accidents. Families receive quarterly newsletters. The service has a Facebook page and skype available to families.</p> <p>Interpreter services are available if required. Sixty three percent of staff are able to converse in fluent Te Reo.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Norfolk Lodge is privately owned. The rest home provides care for up to 23 rest home level residents and 17 dementia level of care residents. On the day of audit there were 16 rest home residents (including one younger person under ACC funding) and 16 dementia level of care residents. All other residents were under the ARCC. There were no residents for respite care.</p> <p>Norfolk Lodge's mission and philosophy is identified in the strategic business plan, which is reviewed annually against the goals and records achievements to date. The 2018 strategic business plan has been developed in consultation with the director (owner) and includes environmental goals such as raised garden beds for the rest home and dementia care gardens.</p> <p>There was a change of director in May 2017. The director who lives outside of the region visits three times a month. The nurse manager is a registered nurse (RN) who has been in the role at Norfolk for 13 years. She is supported by an administration manager (non-clinical), relieving RN and long-serving staff. The service contracts a quality/risk consultant (RN) for 10 hours per week.</p> <p>The nurse manager has attended at least eight hours of education within the last year related to managing a rest home including a three-day aged care conference, dementia care education, advance care plan study day and wound care.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is</p>	<p>FA</p>	<p>The relieving RN covers the nurse manager leave. The nurse manager and relieving RNs provide after hour cover.</p>

<p>managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>		
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>The quality and risk management plan and quality and risk policies describe Norfolk Lodge's quality improvement processes. Policies and procedures are maintained by an aged care consultant who reviews policies to ensure they align with current good practice and meet legislative requirements. Quality management systems are linked to internal audits, incident and accident reporting, health and safety reporting, infection control data, surveys and complaints management. Data that is collected is analysed and compared monthly and annually for a range of adverse event data. Data is graphed and made available to staff. Where improvements are identified, corrective actions are developed, implemented and regularly evaluated. Information is shared with all staff as confirmed during interviews. Multidisciplinary meeting minutes evidence discussion around quality data.</p> <p>There are monthly MDT staff meetings, which includes discussion around infection control/health and safety, accidents/incidents, internal audits and outcomes, restraints/enablers, concerns/complaints and surveys. Meeting minutes evidence quality data, trends and analysis including areas for improvement. Staff are required to sign meeting minutes.</p> <p>The administration manager has completed auditor training and oversees the quality assurance programme. There is an internal audit programme that covers environmental and clinical areas. Clinical audits are completed by an RN. Corrective actions have been implemented and signed out. Annual resident/relative satisfaction surveys are completed annually. Results from the surveys are collated and fed back to participants through meetings. All residents and families interviewed were very satisfied with the care and services provided.</p> <p>The nurse manager has responsibility for ensuring staff receive health and safety training during orientation and ongoing. Health and safety is on the agenda at the monthly MDT meetings. The nurse manager and previous directors have had a meeting with a lawyer on the update to the new legislation. Actual and potential risks are documented on the current hazard register. Contractors are required to complete safety work permits. Falls management strategies include sensor mats, and</p>

		interventions are documented in individualised care plans to meet the needs of each resident who is at risk of falling.
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>There is an incident reporting policy that includes definitions and outlines responsibilities. Individual reports are completed for each incident/accident. There is timely RN assessment including after hours for accident/incidents. Incident/accident data is linked to the organisation's quality and risk management programme. Ten accident/incident forms for November 2016 were reviewed including seven unwitnessed falls (five dementia care and two rest home), two challenging behaviours and one absconding. Each incident involved a resident RN clinical assessment (link 1.3.6.1) and follow-up including corrective actions. The nurse manager had completed a section 31 for suspected outbreak in August 2017, however public health advised this was not an outbreak. A section 31 notification form was completed for the absconding incident on the day of audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are human resources policies to support recruitment practices. Six staff files sampled (one nurse manager, one relieving registered nurse, two caregivers, one diversional therapist and one cook) contained all relevant employment documentation. The recruitment and staff selection process require that relevant checks are completed to validate the individual's qualifications, experience and suitability for the role. Performance appraisals were current. Current practising certificates were sighted for the nurse manager, relieving RN and allied health professionals.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed believed new staff were adequately orientated to the service on employment. An annual training programme covering all the relevant requirements is implemented. Attendance records evidence good attendance at education. Additional sessions are provided for night shift staff. All education is evaluated. The service has four Careerforce assessors. Twenty-three of 26 staff have either a level three or level four Careerforce qualification. There are 20 caregivers who work in the dementia unit. Eighteen caregivers have completed the required dementia unit standards. Two caregivers who have been employed less than six months have commenced the dementia unit standards.</p>

		<p>Staff have the opportunity to attend external education such DHB study days. The nurse manager is interRAI trained and is due to attend an interRAI skills booster 12 February 2018.</p> <p>Clinical staff complete competencies relevant to their role including medication competencies, manual handling, restraint, health and safety, hygiene and grooming, infection control, wound, fire safety and first aid.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. The nurse manager is full-time and covers the on-call requirement Monday to Friday. The relieving RN covers the on-call in the weekends.</p> <p>In the rest home, there are two caregivers on the long shift and one short (flexible) shift in the mornings and in the afternoons one long shift and one short shift.</p> <p>In the dementia unit, there are two caregivers on the long shift and one on short shift on mornings; two caregivers on afternoons with one finishing at 9.00 pm. There is one caregiver in each unit on night shift with another caregiver sleeping over in a flat on-site. Caregivers complete laundry duties as part of their duties. There is a designated cleaner on mornings seven days a week. There is a diversional therapist in each unit Monday to Friday. Caregivers stated there is enough time in their shift to complete all cares and laundry duties on their shifts. Residents and relatives interviewed inform there are sufficient staff on duty at all times. There is the flexibility on the roster to increase hours to meet resident acuity.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The residents' files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into each resident's individual record. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents' files are protected from unauthorised access by being held in cupboards in each nurse's station. Archived records are secure in a separate locked area. Residents' files demonstrate service integration. Entries are legible, dated, timed and signed by the relevant caregiver or RN, including</p>

		designation.
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>There are policies and procedures to safely guide service provision and entry to services including an admission policy. The service has an information pack available for residents/families at entry. The admission agreements reviewed meet the requirements of the ARCC. Exclusions from the service are included in the admission agreement. All five admission agreements viewed were signed and dated.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Policy describes guidelines for death, discharge, transfer, documentation and follow-up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities and communication with family is made.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were no residents self-administering on the day of audit. There are no standing orders. There are no vaccines stored on-site.</p> <p>The facility uses an electronic and medico pack system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. Caregivers administer medications in the rest home and dementia unit. Staff attend annual education and have an annual medication competency completed. The medication fridge temperature is checked weekly. Eye drops are dated once opened.</p> <p>Staff sign for the administration of medications on the electronic system. Twelve medication charts were reviewed (six rest home and six dementia). Medications are reviewed at least three monthly by the GP. There was photo ID and allergy status recorded. 'As required' medications had indications for use charted.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The service has one cook who covers Monday to Friday and one cook who covers Saturday and Sunday. Both have current food safety certificates. The head cook oversees the procurement of the food and management of the kitchen. There is a well-equipped kitchen and all meals are cooked on-site. Meals are served directly from the kitchen in</p>

		<p>the rest home and from a trolley in the dementia unit. The food is kept warm by insulated covers. Special equipment such as lipped plates is available.</p> <p>On the day of audit meals were observed to be well presented. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures were monitored and recorded weekly. Food temperatures are checked, and these were all within safe limits. The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes were noted on a kitchen whiteboard. The four-weekly menu cycle is approved by a dietitian. All residents/families interviewed were very satisfied with the meals. There are snacks available 24 hours.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The service records the reason for declining service entry to residents should this occur and communicates this to residents/family. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and/or their family where appropriate. Files sampled contained the interRAI assessment tool and this is reviewed at least six monthly or when there is a change to a resident's health condition. Care plans sampled were developed on the basis of the interRAI assessment.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. All care plans are resident-centred. Interventions documented support needs and provide detail to guide care. All dementia long-term care plans had clear guidelines for staff on behaviour management. Short-term care plans are in use for changes in health status. Residents and relatives interviewed stated that they were involved in the care planning process. There was evidence of service integration with documented input from a physiotherapist, dietitian and the mental health team for services to older people. The</p>

		care staff interviewed advised that the care plans were easy to follow.
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Moderate</p>	<p>When a resident's condition changes the registered nurse initiates a GP consultation. Staff state that they notify family members about any changes in their relative's health status. All care plans sampled had interventions documented to meet the needs of the resident and there is documented evidence of care plans being updated as residents' needs changed.</p> <p>Resident falls are reported on accident forms and written in the progress notes. Neurological observations are taken when there is a head 'knock' or for an unwitnessed fall. These are not always completed according to protocol. Care staff interviewed state there are adequate clinical supplies and equipment provided including continence and wound care supplies and these were sighted.</p> <p>Wound assessment, wound management and wound evaluation forms are documented on short-term care plans in place for all wounds. Wound monitoring occurs as planned. There is currently one wound being treated. There are currently no pressure injuries.</p> <p>Monitoring forms are in use as applicable such as weight, vital signs and wounds. Behaviour charts are available for any residents that exhibit challenging behaviours.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>There is one diversional therapist who works 30 hours a week and one recreational officer (completing the diversional therapy course) who works 15 hours a week. The diversional therapist works across the facility, but the recreational officer only works in the dementia unit. On the days of audit, residents were observed participating in exercises, playing quoits, going out on a van outing and listening to a newspaper reading. One resident was helping the gardener.</p> <p>There is a weekly programme in large print on noticeboards in all areas. Residents have the choice of a variety of activities, in which to participate and every effort is made to ensure activities are meaningful and tailored to residents' needs. These include exercises, house, news from the paper, music, walks outside and games.</p> <p>Those residents who prefer to stay in their room or who need individual attention have one-on-one visits to check if there is anything they need</p>

		<p>and to have a chat.</p> <p>There is a monthly church service, the chaplain visits every Wednesday and the priest on a Sunday.</p> <p>Each area has a van outing weekly. Special events like birthdays, Easter, Mothers' Day, Anzac Day and Matariki are celebrated. Last Matariki the residents celebrated at the local Marae. The facility has two cats, both of whom the residents take great joy from. There is community input from the local marae and the Kohanga Reo. Some rest home residents go out to an Age Concern group.</p> <p>Residents have an activity assessment completed over the first few weeks following admission that describes the residents past hobbies and present interests, career and family. Resident files reviewed identified that the comprehensive individual activity plan is based on this assessment. Activity plans are evaluated at least six monthly at the same time as the review of the long-term care plan.</p> <p>Resident meetings are held three monthly.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>The six care plans reviewed had been evaluated by the registered nurse six monthly or when changes to care occurred. Short-term care plans for short-term needs are evaluated and signed off as resolved or added to the long-term care plan as an ongoing problem. Activities plans are in place for each of the residents and these are also evaluated six monthly. The multidisciplinary review involves the RN, GP and resident/family if they wish to attend. There is at least a three-monthly review by the GP for rest home and dementia residents. The family members interviewed confirmed that they are informed of any changes to the care plan.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where residents had been referred to the physiotherapist and mental health services for older people. Discussion with the registered nurse identified that the service has access to a wide range of support either through the GP, specialists and allied health services as required.</p>

<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>There are policies regarding chemical safety and waste disposal. Staff have completed chemical safety and waste disposal training. All chemicals are clearly labelled with manufacturer's labels and stored in locked areas. Safety datasheets and product sheets are available. Sharps containers are available and meet the hazardous substances regulations for containers. The hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. Gloves, aprons, and goggles are available for staff.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building holds a current warrant of fitness which expires 3rd May 2018. There is a maintenance person/gardener on-site twenty-four hours a week, but this is flexible and he is on call as required.</p> <p>Electrical equipment has been tested and tagged. The hoist and scales are checked annually. Hot water temperatures have been monitored randomly in resident areas and were within the acceptable range. The communal lounges and hallways are carpeted. The utility areas such as the kitchen, laundry and sluice rooms have vinyl flooring. Residents' rooms are carpeted in the rest home and have vinyl in the dementia unit. Communal showers and toilets have non-slip vinyl flooring. All halls have safety rails and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens were well maintained. The dementia unit garden is safely fenced off. The facility won the Waitara garden of the year in 2017. All outdoor areas have some seating and shade. There is safe access to all communal areas.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are no ensuites. All rooms share communal showers and toilets and there are hand basins in each room. Fixtures, fittings and flooring are appropriate. Toilet/shower facilities are easy to clean. There is ample space in all toilet and shower areas to accommodate shower chairs. There are privacy signs on all shower/toilet doors. These are written in English and Māori.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas</p>	FA	<p>All resident's rooms are single. They are sufficiently spacious in the rest home and dementia unit to allow care to be provided and for the safe use of mobility equipment. Staff interviewed reported that they</p>

appropriate to the consumer group and setting.		have more than adequate space to provide care to residents. Residents are encouraged to personalise their bedrooms as viewed on the day of audit.
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	There are large and small communal areas. Activities occur in the larger areas and the smaller areas are spaces where residents who prefer quieter activities or visitors may sit. All lounges have access to the lovely garden and on a good day the small lounge in the dementia unit has a view of Mt Taranaki. There are dining rooms in each wing.
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	Laundry is done on-site by caregivers. There is a laundry in the rest home and dementia unit. The laundries are divided into a "dirty" and "clean" area. There is a laundry and cleaning manual. Cleaning and laundry services are monitored through the internal auditing system. The cleaner's equipment was attended at all times or locked away in the cleaner's room as sighted on the day of the audit. There is a cleaner in each area. There are sluice rooms for the disposal of soiled water or waste. The sluice rooms and the laundries are locked when not in use.
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	Emergency, disaster policies and procedures are documented for the service. The service has an approved fire evacuation scheme dated May 2000. Fire drills occur every six months with the last in August 2017. The orientation programme and two-yearly education/training programme include fire, security and emergency/civil defence situations held last in December 2017. Staff interviewed confirmed their understanding of emergency procedures. There are adequate supplies available in the event of a civil defence emergency including food, water, torches and other civil defence supplies. A gas BBQ and gas cooking in the kitchen are for cooking. There is a generator on-site for emergency power back-up for lights and call bells. A call bell system is in place including all resident rooms and communal areas. Residents were observed in their rooms with their call bell within reach. There is at least one staff member on duty 24 hours a day with a current first aid certificate. The building is secure with surveillance cameras internally and externally.
Standard 1.4.8: Natural Light, Ventilation, And Heating	FA	All bedrooms and communal areas have ample natural light and

<p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>		<p>ventilation. All heating is electrical. Staff and residents interviewed stated that this is effective. There is a deck area where one resident smokes. All other areas are smoke free.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>The nurse manager has responsibility for coordinating the infection control programme for the facility. Responsibility for infection control is described in the job description. The infection control coordinator/nurse manager is responsible for the collation of infection events. The infection control coordinators report to the director/owner and to the infection control committee and staff meeting.</p> <p>Visitors are asked not to visit if unwell. Hand sanitisers are appropriately placed throughout the facility. Influenza vaccines are offered.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The infection control coordinator has attended infection control and prevention education as part of an aged care conference and completed the on-line Ministry of Health course. Other infection control education is provided through the DHB. There is access to infection control expertise within the DHB, aged care consultant, wound nurse specialist, public health, laboratory and GPs.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>The infection control policies include a comprehensive range of standards and guidelines including defined roles and responsibilities for the prevention of infection; and training and education of staff. Infection control procedures developed in respect of the kitchen, laundry and housekeeping incorporate the principles of infection control. The policies have been developed by an aged care consultant.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The infection control coordinators are responsible for coordinating/providing education and training to staff. Training on infection control is included in orientation and as part of the annual training schedule held September 2017. Staff complete infection control questionnaires. Hand hygiene competencies are completed during orientation and annually. Resident education is expected to occur as part of providing daily cares.</p>

<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information obtained through surveillance to determine infection control activities and education needs in the facility. Infection control data is discussed at the monthly combined infection control/health and safety committee meetings and MDT staff meetings. Data and graphs of infection events are available to staff. The service completes monthly and annual comparisons of infection rates for types of infections. Trends are identified, analysed and areas for improvement identified.</p> <p>Systems in place are appropriate to the size and complexity of the facility. There have been no outbreaks.</p> <p>Policies and procedures document infection prevention and control surveillance methods. The surveillance data is collected and analysed monthly to identify areas for improvement or corrective action requirements. Infection control internal audits have been completed. Infection rates have been low. Trends are identified, and quality initiatives are discussed at staff meetings. There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place that are appropriate to the complexity of service provided.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>There are current policies that reflect best practice and meet the restraint minimisation standard around restraints and enablers. The nurse manager is the restraint coordinator and has a job description that defines the role and responsibilities. No residents were using restraints or enablers on the day of audit.</p> <p>Care staff interviewed were able to describe the difference between an enabler and a restraint. Care staff complete restraint questionnaires. Staff receive training around restraint minimisation (July 2017) and managing challenging behaviours (November 2017).</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA</p> <p>Moderate</p>	<p>There are protocols in place in order for the provision of services and/or interventions to meet the residents' assessed needs and goals (eg, weights are checked monthly) and if a resident has lost weight they are commenced on Fortisip or referred to the dietitian if required. Neurological observations are commenced if a resident has a fall and hits their head or has an unwitnessed fall, but these are not always completed according to protocol.</p>	<p>Neurological observations have not been completed as per protocol for five (dementia) unwitnessed falls and two (rest home) unwitnessed falls in the month of November 2017.</p>	<p>Ensure neurological observations are completed as per protocol.</p> <p>30 days</p>

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
<p>Criterion 1.1.4.2</p> <p>Māori consumers have access to appropriate services, and barriers to access within the control of the organisation are identified and eliminated.</p>	CI	<p>The service incorporates the principles of the Treaty of Waitangi and recognition of Māori cultural values and beliefs across all areas of service delivery including communication, language, care, recreational, spiritual and foods. Feedback from three Māori residents and one Māori relative praised Norfolk Lodge management and staff for the way in which their culture was recognised and stated their cultural needs were being well met.</p>	<p>At Norfolk Lodge, 27% of residents are Māori (seven residents). Cultural values and beliefs are identified on admission through resident and whānau consultation. The service has strong links with a local Māori provider Tui Ora and has an Iwi representative on the DHB. The local Iwi radio station has a strong connection with Norfolk Lodge and its residents, making birthday calls and tributes to residents who have passed away. The station promotes events happening within the community and at the lodge. Māori residents are invited to events and can participate as desired including attending the Marae, mirimiri (cultural treatments, primary school kapa haka and other performances that relate to Matariki). The recreation programme recognises and celebrates significant cultural days such as Matariki, Waitangi Day and Māori language week.</p>

			<p>The service has a Māori Reverend who has been associated with the service for eight years. She visits weekly for church services and is available at any other time for resident and staff counselling and support. The Reverend also blesses rooms and supports family/whānau with visits and karakia (prayer). The service also has a strong connection with the Ratana Marae affiliations who also provide cultural/spiritual support for residents as requested. There are many Māori community visitors who perform waiata and kapa haka and special performances for kaumātua birthdays and other festivities. Traditional Māori kai (food) is cooked at least fortnightly for Māori and non-Māori to enjoy as desired.</p> <p>There are a number of Māori staff at Norfolk (62%) with 63% of all staff able to converse fluently in Te Reo with Māori residents having a positive impact on the cultural and emotional well-being of the residents and their whānau. Six staff (five caregivers and one cook) completed a funded Careerforce qualification for Māori TDHB Haurora. One staff member has a degree in Māori Te Reo and another staff member is a training Te Reo teacher. Staff “live and breathe” the culture with daily karakia and participation in kapa haka competitions. Norfolk Lodge exceed the standard around recognising and meeting the cultural, spiritual values and beliefs of Māori. Three Māori residents and one Māori relative interviewed commented very positively on the provision for Māori across all areas of service.</p>
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End of the report.