# Norfolk Court Home & Hospital - Norfolk Court 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 Q-Audit 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:** Norfolk Court Home & Hospital 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: 30 January 2018 End date: 31 January 2018

**Proposed changes to current services (if any):** None

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

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

## General overview of the audit

Norfolk Court Rest home provides rest home, hospital and dementia level care for up to 63 residents. The rest home had a change of ownership in April 2017.

This combined audit was conducted to assess compliance against all the requirements of the Health and Disability Services Standards and the provider’s contract with the district health board (DHB). The audit included interviews with management, residents, staff, family members and the general practitioner (GP). Policies, procedures, records and documents were reviewed and sampled. Observations were included.

At the time of the audit the provider had three remaining corrective actions to address. These corrective actions were identified at the audit conducted during the change in ownership (March 2017) and are being monitored by the DHB. One of these was closed during the audit following discussion and approval from the DHB. This was due to the significant progress which has been made.

There are now four areas where improvements are required in order to achieve full compliance. These include two previous improvements regarding timeframes for service delivery and attendance at staff education, and two newly identified areas of improvement regarding medications and progress notes.

## Consumer rights

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

Documented procedures, interviews with residents, family members and staff, together with observation confirmed that residents’ rights are understood and met in everyday practice. Communication channels are clearly defined and interviews and observation confirmed 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 managing director has an open-door policy.

Informed consent requirements are clearly defined and residents and staff members interviewed confirmed 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 residents.

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

## 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. |  | Some standards applicable to this service partially attained and of low risk. |

Norfolk Court Rest Home is currently privately owned and governed by two directors, one of whom is the managing director (MD). The purpose, values, scope, direction and goals of the organisation have been reviewed and key targets are monitored. The MD is supported by the clinical nurse manager (CNM).

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

## Continuum of service delivery

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| --- | --- | --- |
| 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. |

There is a clear admission pathway that helps in the placement of assessed residents in appropriate level of care. The registered nurses are responsible for the development of care plans. Care plans are evaluated, reviewed and amended when clinically indicated by a sudden change in resident’s status.

Planned activities are appropriate to the residents’ assessed needs and abilities. In interviews, residents and family/whanau expressed satisfaction with the activities programme in place.

There is a medication management system in place. Medication is administered by staff with current medication competencies. All medications are reviewed by the general practitioner (GP) according to policy. 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 standards.

## Safe and appropriate environment

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

The 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 (the Haven) 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 residents. 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.

## Restraint minimisation and safe practice

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| --- | --- | --- |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |

There are clear and detailed documented guidelines on the use of restraints, enablers and challenging behaviours. There were 11 residents using restraint and none on enablers at the time of the audit. Staff interviewed were knowledgeable on the use of restraints and enablers and receive ongoing restraint education. Environmental restraint is in place for residents in the secure dementia unit in the form of coded locked doors however visitors come and go as they please.

## Infection prevention and control

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

Infection control management systems are in place to minimise the risk of infection to residents, visitors and other service providers. The infection control coordinator is responsible for coordinating education and training of staff. The infection control programme is reviewed annually.

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 in a timely manner.

## Summary of attainment

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 46 | 0 | 3 | 1 | 0 | 0 |
| **Criteria** | 0 | 97 | 0 | 3 | 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](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).

|  |  |  |
| --- | --- | --- |
| **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 reflect the Code of Health and Disability Services Consumer Rights (the Code). The Code is included in the orientation of all new staff and staff interviewed demonstrated knowledge of the Code. The Code is also discussed as part of the annual in-service education programme. Residents and relatives interviewed, and observation during the audit, indicated that staff understand resident rights and their responsibilities and that resident rights are observed in practice. |
| 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 | Policies and procedures on consent support the residents’ right to make informed decisions. Having heard all options in a form they understand and to have consent obtained before any health teaching or health research; or collection and use of information for administrative or epidemiological purpose; or procedures and treatment; is commenced and carried out. The residents also have the right to refuse treatment and/or medication, in the clear knowledge of the possible medical consequences if such is refused. The policy references Rights 5, 6 and 7 of the Code and the process for determining competency and advanced directives.  The residents' files sampled had the required consent forms signed by the resident, or when appropriate, signed by the enduring power of attorney (EPOA). Staff acknowledged the resident's right to make choices based on information presented to them. Residents interviewed confirmed that they were provided with day to day choices and consent was obtained. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | The advocacy policy details contact information for the Health and Disability Commission and Age Concern advocacy services. Information about the right to advocacy and contact details for local services is included in the information given and explained to residents and families on admission. Staff training on the right to advocacy / support is provided annually. A local community advocate visits the rest home on a regular basis, and when requested. |
| 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 are no set visiting hours and relatives are encouraged to visit at any time. Family/whanau reported that there were no restrictions to visiting hours. Residents are supported and encouraged to access community services with visitors or as part of the planned activities programme. Evidence of community access was sighted in resident records sampled. |
| 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 are in line with Right 10 of the Code. Residents and family/whanau interviewed confirmed access to the complaints procedure. The complaint forms are readily available, as are the contact details for advocacy services.  A complaints register is maintained. This includes the nature of the complaint, actions and outcomes. The most recent complaint (January 2018) is still under investigation by management; however, there is evidence that the complainant is being kept informed. The managing director acknowledges each complaint in writing and includes Norfolk Courts responsibility. Apology letters were sighted, in the event the complaint has been substantiated. There was also evidence of advocacy involvement in complaint records sampled. There was a complaint made to the district health board (DHB) in September 2017. This was investigated by the DHB and has since been closed.  An analysis of complaints, including trends and outcomes has been completed by the managing director. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | Information about the Code, advocacy services and the complaints process is provided on admission and displayed for easy access. The Code is available in Maori and English.  Residents and families interviewed are aware of their rights and confirmed that information was provided to them during the admission process. Signed residents’ agreements were sighted in records sampled. Service agreements meet the requirements of this standard and district health board requirements. |
| 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 | The privacy and dignity policy details how staff are to ensure the privacy of residents, ensuring the protection of personal property and maintaining the confidentiality of residents’ related information. The process for accessing personal health information is detailed and the care planning process identifies and records interventions for respecting resident’s individual beliefs and values. Personal property is maintained in a secure manner. Policies and procedures on abuse and neglect include definitions and reporting requirements. Observations made during the audit confirmed that staff were respectful of personal privacy during the delivery of care and when entering residents’ rooms. |
| 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 | The Maori Health Plan includes Maori models of health and barriers to access. Cultural needs are included in the care plans (if identified). There is access to cultural advice, resources and documented procedures to ensure recognition of Maori values and beliefs. The organisation maintains contact and input from a local kaumatua. Cultural safety training is provided to all 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 | Cultural needs are identified on admission and a management plan is developed to ensure that care and services are delivered in a culturally and/or spiritually sensitive manner in as recognised by the resident. Values and beliefs are discussed and incorporated into the care plans. Residents and family members interviewed confirmed they are encouraged to be involved in the development of the long-term care plan and are given the opportunity to discuss their individual needs. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Policies define processes for providing an environment that is free from discrimination, coercion, harassment, sexual, financial or other exploitation. The staff code of conduct, house rules and professional behaviour are included in the employment and orientation process. Staff receive information and education regarding non-discriminatory attitudes and behaviours.  Interviews with residents and family, and observation during the audit, indicated that residents are free of any form of coercion or discrimination. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | Good practice is maintained, encouraged and monitored. Staff reported that they are satisfied with the relevance of the education provided and were able to explain how they maintain good practice. Policies and procedures are linked to evidence-based practice. There are regular visits by the GP and allied health providers as required. The clinical nurse manager is an experienced registered nurse. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Staff education has been provided related to appropriate communication methods. The service has required access to interpreting services for the residents. Policies and procedures are in place if the interpreter services are needed to be accessed. Documenting of open disclosure following incidents/accidents was evident. Families reported they are informed of any events or concerns. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Norfolk Court Rest Home is owned and operated by the two directors who purchased the rest home in April 2017. One of the directors is the managing director (MD) and the other works as the administration manager. The MD has a background in management. The administration manager has a back ground in administration and accounts. A provisional audit was conducted in March 2017 to assess the new owner’s readiness to own/manage the facility.  The MD remains abreast of current trends in the aged care sector through attendances at regional provider meetings. Minutes of the New Zealand Aged Care Association Northland provider meeting were sampled and confirmed attendance of the MD.  A comprehensive business plan (May 2017) was developed and is now being operationalized. This includes strategic outcomes 2022. The strategic imperatives for 2018 have been documented with associated goals for monitoring including actions and responsibilities. The mission statement for the organisation has remained the same; however, the vision, values and philosophy have been reviewed and amended to reflect the intentions of the new owners. A current organisational chart was sighted.  The rest home is certified to provide 63 residential beds. This includes 35 dual purpose beds (for residents requiring either rest home or hospital level care), 7 rest home level beds and a 15-bed secure dementia unit (the Haven). A number of the dual purpose and rest home rooms can operate as double rooms if required.  There were 53 residents on the day of the audit. This included 14 residents in the Haven, 32 dual residents occupying dual purpose beds and 7 residents occupying rest home beds). Norfolk Court can also provide respite services, long term and short term stays if required. |
| 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 MD is supported by the clinical nurse manager. The clinical nurse manager (CNM) was the previous facility manager, is an experienced registered nurse and has been with the organisation for seven years. The ‘Lines of Communication and Formal Reporting’ policy includes delegations to the CNM in the absence of the MD. |
| 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. | FA | There is a documented quality and risk management system which is compliant to requirements of this standard and the contract with the DHB. A large amount of work has occurred over the last 10 months to ensure that procedures are current and reviewed as required. All critical processes have now been reviewed. Clinical policies and procedures have all been reviewed by the CNM. Administrative/management policies and procedures have been reviewed by the MD. The ongoing review on non-critical processes will continue as business as usual. A manual master index has been maintained and demonstrates currency of all documents.  Organisational performance is closely monitored. A quality plan has been documented in measurable terms. The MD maintains a comprehensive schedule of all monitoring and performance requirements. This includes the implementation of routine, and extraordinary, internal audits. The organisation has also registered with a benchmarking group where clinical indicators are set and measured on a monthly basis.  Quality related data is being collated and trends identified. Quality data is now discussed in a range of forums including the management team meetings, clinical quality group meetings and health and safety meetings. Any identified area of non-conformance is fully investigated with corrective actions monitored for improvements. The CNM also maintains records of ongoing improvements being made to clinical operation systems. This includes the identified improvement, rational, actions, timeframes and monitoring requirements. Resident satisfaction surveys are conducted and there is sufficient evidence that feedback regarding the results of surveys, and any related corrective actions, have been shared with the residents during residents’ meetings.  Organisational risk is documented. Risk management process is discussed in the business plan and the MD is currently finalising the risk register. There is a current hazard identification and management system. There is evidence of risk monitoring in meetings minutes sampled. A significant identified risk to the organisation has been the recruitment and retention of registered nurses. Actions are now in place to ensure the registered nurse workforce will be stable now for the next three years. |
| 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. Clinically related incidents and accidents are forwarded to the CNM with all others forwarded to the MD. 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 clinical quality group meetings and management meetings. A full analysis of all adverse events for 2017 was sighted.  Records of incident and accident reports were sampled. There was evidence of the required immediate actions, assessment, observations and preventative actions. Essential notifications were made as required. Serious assessment codes (SAC) are used. There is evidence that the police, Ministry of Health, DHB, general practitioner 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 Low | 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 a process for recruitment screening and the validation of professional qualifications for both employed and external health professionals. 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.  An internal audit was conducted by the MD on 100% of staff files. This identified a number of random gaps in staff information and records. A comprehensive report and corrective action plan was developed and is currently being implemented. Evidence sighted on the day of the audit confirmed that progress has been made. Achievement towards full compliance with staff records is being monitored by the MD weekly.  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 traditionally been fewer than expected and an improvement is required.  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 staff who require them. All staff have a current first aid certificate.  The service conducts a performance appraisal process. Performance appraisals were delayed in 2016 due to frequents changes in staff and the change in management. Significant work has been completed to ensure appraisals are up to date. A schedule of those still requiring an appraisal has been documented and there is evidence that this is being closely monitored by the MD. |
| 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 organisation employs 38.25 full time equivalent staff. This is a combination of management, registered nurses, care givers, administration staff and housekeeping staff (including maintenance). The largest group of employees is care giver staff with a total of 30. There are currently five registered nurses, plus the CNM.  A full review of staffing was conducted by the DHB in November 2017 following a complaint regarding staffing numbers. It was acknowledged that there have been numerous difficulties in recruitment and retention of the registered nurse workforce. Recommendations made during the review are being closely monitored by the DHB.  Current staffing numbers meet contractual requirements. There is a one registered nurse per shift plus the CNM during business hours Monday to Friday. The registered nurses have also been allocated four shifts per week to address clinical pathway and quality improvement tasks such as creating, updating and reviewing care plans. A registered nurse is also rostered a shift to attend the weekly medical clinic. The number of caregivers rostered per shift is sufficient.  Rosters were sampled to ensure appropriate numbers of staff and cover in the event of a temporary absence. Care staff have the opportunity to swap shifts on the condition they swap with another staff member with similar skills and experience. Records of shift swaps were sighted in the communication book. There was also evidence in the communication book that shifts were covered in the event of staff absence.  The staffing allocation policy and procedure has been updated recently to reflect the contract requirements. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | PA Low | A full review of residents’ records management was completed by the MD. This resulted in a change to the format of records to ensure better consistency. Records of current and previous residents are securely maintained.  Residents' demographic information is documented on entry. The admission assessment includes verification and documentation of individual resident information. The sample of residents’ records indicates that they include reports from all health professionals. Records are integrated in the one file. Entries are legible, dated, signed and designated; however an improvement is required to ensure the time of entry is included when writing progress notes. |
| 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 | Entry to service is facilitated in a competent, equitable, timely and respectful manner. 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 reviewed. The pre-admission questionnaire is completed and admission pack given on entry. 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 notification from the DHB is utilised when residents are required to be transferred to the public hospital or another service. Residents and their family/whanau are involved in all exit or discharges to and from the service and sufficient evidence in the residents’ records to confirm this and 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. | PA Low | There is a documented procedure which describes implementation of the medicine management system. Policies and procedures are aligned with legislation, guidelines and good practice.  The service uses pharmacy pre-packed medication packs that are checked by the RNs on delivery. Medications are safely stored. Medication reconciliation is conducted by the RNs when a resident is transferred back to service. Stocked medication is used for hospital level residents only. All medications for rest home residents is individually prescribed. There is a process for the administration of ‘as required’ medication.  All medication records 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.  Medication competencies are maintained. A RN and a caregiver were observed administering lunch time medications correctly in their respective areas.  There was one resident self-administering an inhaler at the time of the audit. The resident had been assessed as competent when using the inhaler. There is a policy and procedure for self-administration of medication if required.  An area of improvement was identified regarding stock take of controlled drugs. |
| 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 | The meal services are prepared on site and served in the allocated dining rooms. The service employs two cooks who work from Monday to Thursday and Friday to Sunday. The menu has been reviewed by a dietitian to confirm it is appropriate for the nutritional needs of the residents. The feedback from residents indicated that they needed variety in the meals and a dietitian is booked to review the menu on the 05 February 2018. There is a four-weekly rotating winter and summer menu in place.  The residents have an ‘advice to food service’ developed on admission which identifies dietary requirements, likes and dislikes and is required to be communicated to the kitchen including any recent changes made (refer standard 1.3.3.  Diets are modified as required and the cook confirmed awareness on dietary needs required by individual residents. Meals are served warm in sizeable potions required by residents and any alternatives are offered as required. Residents’ weights are not consistently monitored (refer standard 1.3.3). Nutritional supplements are provided to residents with identified weight loss issues.  The kitchen and pantry were observed to be clean, tidy and stocked. Labels and dates are on all containers and records of food temperature monitoring, fridges and freezers temperatures are maintained. Regular cleaning is completed. Staff who work in the kitchen have completed the Norfolk Court Food Services training. |
| 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 CNM 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. The data is captured on the enquiry resident form. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | The initial assessments are completed within the required time frame on admission, while long term care plans are completed within three weeks of admission to the facility. 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, and as required. Nutritional assessments and activity assessments are also completed on admission and are required to be updated accordingly. There is sufficient evidence that assessment data is utilised to inform care plans (refer standard 1.3.3).  In interviews, the family/whanau expressed satisfaction with the support provided. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | There are documented processes for ensuring that long term care plans are resident focussed, integrated and provide continuity of service delivery. Long and short-term care plans are developed with nurse’s specific instructions provided for care givers. Goals are appropriate, congruent and achievable. Interventions are detailed enough to address the desired goals/outcomes identified during the assessment process. The residents and 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 both short term and long-term care plans are sufficient to address the residents’ assessed needs and desired goals/outcomes. Any 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 (refer standard 1.2.9). 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. Short term care plans had required interventions to address any short- term problems identified. |
| 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 | Activities are appropriate to the needs, age and culture of the residents. The activities coordinator develops an activity planner and daily/weekly activities are posted on the notice boards in all wings. Residents’ files have a documented activity plan that reflects the residents’ preferred activities of choice. Activity progress notes are completed daily. The activities vary from art and craft, bingo, music, dancing, van trips, exercises/walking and church services. The activities coordinator reported that they have group activities and also engage in one on one activities with some residents. Activities are modified to varying abilities and cognitive ability.  Over the course of the audit residents were observed being actively involved in a variety of activities. Family/whanau and residents interviewed expressed satisfaction with the activities programme in place.  Activity care plans are reviewed six monthly or when there is any significant change in participation and this is done in consultation with the RNs. The resident’s activities daily report was evident in the files sampled.  A number of 24-hour activity plans (in the Haven) and in the rest/hospital wings were sampled, however these have not been consistently completed (or updated) in line with the required timeframes (refer standard 1.3.3). |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | There is a process for conducting regular evaluations. This includes the evaluation of long term care plans, interRAI assessments, nutritional advise to the kitchen and activity plans every six months (refer standard 1.3.3).  The evaluations sampled record how the resident is progressing towards meeting their goals and responses to interventions. Short term care plans have been developed when needed and signed, dated and closed out when the short- term problem has resolved. The GP reviews all medical needs every three months.  Family/whanau and staff input is sought in all aspects of care. |
| 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 utilises 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, CNM and RNs. |
| 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. Hazardous substances, for example oxygen cylinders are safely stored.  All staff receive training on the use of personal protective equipment (PPE) and the management of waste and hazardous substances. Staff were observed using PPE correctly during the audit. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | There have been no changes to the building or plant since the last audit. The building is separated into three distinct areas. The Haven and three 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. Central corridors are wide enough to accommodate mobility equipment and aids. There are safe handrails and ramps.  There is a current building warrant of fitness. Electrical testing is conducted. Medical equipment is calibrated. Furniture is provided and maintained in good order. There is a routine maintenance schedule which is being implemented as required. There is also evidence that ongoing maintenance requests are actioned in a timely manner.  There is a documented and implemented health and safety programme. A health and safety statement is documented and displayed. All hazards are identified. These are discussed monthly by the recently established health and safety committee. The health and safety programme also includes a process for ensuring contractor safety when on site.  At the time of the audit, a new roof was being installed over the older part of the building in order to prevent leakage leakage into the building. |
| 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. 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. 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 | There are a number of rooms which can be used as double rooms if required. At the time of the audit, one of the rest home double rooms was being shared by a couple. There are separate call bells and privacy curtains in this room. There is a consent process for sharing double rooms if required. All other rooms are single occupancy. All residents’ 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. 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. Material data safety sheet are displayed. Cleaning and laundry hazards are documented.  The MD has completed a review of cleaning and laundry processes. Cleanliness and laundry standards are monitored through internal audits and resident feedback. The facility is observed to be clean on the days of the audit. No hazardous chemicals were accessible. |
| 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.  The emergency management plan has been reviewed and a copy provided to the DHB. Outbreak management and pandemic planning is current with sufficient supplies of food, equipment and water in the event of an emergency. The building has emergency lighting in the event of a power failure, there is a BBQ, 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 Haven 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. This was confirmed in staff records and interviews. All staff have a current first aid certificate. |
| 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 | Norfolk Court Rest Home provides an environment that minimises the risk of infection to residents, staff and visitors by implementing an appropriate infection prevention and control programme. 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 daily 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. In interview conducted with the infection control coordinator (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 residents, staff and visitors to use. 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 has access to external specialist advice from the GPs’, DHB, infection control specialists (when required) and is a member of the New Zealand Nurses Organisation (NZNO) infection control forum.  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 as when necessary. The ICC has access to all relevant resident data to undertake surveillance, internal audits and investigations respectively. |
| 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 | Infection prevention and control policies and procedures 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 were able to locate policies and procedures. |
| 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 infection prevention and control training for staff. Training and attendance records are maintained. The infection prevention and control training education information pack is detailed and meets required legislative and current regulations. Infection control is part of the orientation programme and all staff 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 | Norfolk Court Rest Home aim to minimise the use of restraint. An updated restraint register was sighted and staff interviewed understand the difference between restraint and enablers. Risk minimisation was documented in the care plans of the residents and restraint use is evaluated regularly. Approved equipment which can be used as restraint is defined. There were 11 residents on restraint and none using enablers for safety and comfort at the time of the audit. The family and residents are fully informed about the restraint process and risks involved. |
| 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 CNM 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. The approval process is in place and includes the CNM, GP, resident (if appropriate) and family members. Restraint use is discussed in management, clinical quality and staff meetings. |
| 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 any resident who demonstrates that the use of restraint maybe indicated. 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, coordinator and family/whanau. The required assessments and consents were sighted in all restraint records sampled. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | A current restraint register was sighted. The long-term care plans have documented risk management plans required to ensure the resident’s safety while on restraint. The service has 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 the resident, family/whanau, restraint coordinator and the GP. The approval process ensures the environment is appropriate and safe. Restraint use is reviewed at least three monthly and six monthly and as part of restrain register reviews. Staff interviewed demonstrated understanding about restraints and strategies to promote safe practice.  The restraint monitoring and observation process is included in the restraint policy. There were no restraint related injuries reported. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | Regular reviews on restraint use are conducted and this was evident in the records sampled. The GP confirmed involvement in the restraint review process. Reviews include 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 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 meetings. Individual restraint approvals are completed 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 review of restraint use. The CNM reported that assessments and monitoring are appropriate. Policies and procedures are up to date and a training record was sighted and annual reviews are completed. |

# 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 1.2.7.5  A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Low | Due to the low attendance of staff at mandatory in-service training days, it is now planned to implement a one-day (eight hour) compliance session addressing all compulsory education. It is anticipated that the first compliance day will be in March 2018. This was a previous corrective action identified during the provisional audit in May 2017 and is being monitored by the DHB until completion. | In service education includes the mandatory training topics as required. Records of in-service training confirmed low attendance. | Staff are not consistently attending mandatory training.  60 days |
| Criterion 1.2.9.1  Information is entered into the consumer information management system in an accurate and timely manner, appropriate to the service type and setting. | PA Low | Staff are required to write a progress notes during each shift, with additional entries if there has been a change or specific event. Progress notes were sampled and confirmed routine entries per shift. The date and designation of the writer were documented; however the time of entry has not been consistently recorded. | Progress notes sampled did not consistently include the time of entry. | Staff are required to record the time when writing a progress note.  60 days |
| Criterion 1.3.12.6  Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines. | PA Low | Controlled drug legislation requires a weekly (and six monthly) stock take. Although the controlled drugs were being reconciled weekly with the deliveries from the pharmacy, the required weekly and six-monthly checks had not been completed. | Routine stock take of control drugs has not been occurring. | Complete the required routine stoke take of controlled drugs.  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 | The previous audit identified three areas where timeframes in service provision were not being consistently met. These included the completion of interRAI assessments, routine monitoring and care plan updates. Progress towards meeting these timeframes has been monitored by the DHB with evidence of ongoing improvements.  This audit identified an additional four areas where timeframes were not being met. This included the completion of 24-hour activities care plans in the Haven, activity care plans in the rest home/hospital, updating residents’ nutritional advice to the kitchen and conducting routine evaluations.  The risk rating has not been raised to high in consideration of the ongoing work and monitoring which is being conducted to address the situation. The organisation now has a full quota of nursing staff which have each been assigned tasks to address. Newly appointed nurses have also been scheduled to complete interRAI training. | Not all expected timeframes for service provision have been met. | Completion each stage of service provision within the timeframes required.  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.