

Eldson Enterprises Limited - Bradford Manor

Current Status: 5 March 2014

The following summary has been accepted by the Ministry of Health as being an accurate reflection of the Surveillance Audit conducted against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) on the audit date(s) specified.

General overview

Bradford Manor provides dementia level care for up to 26 residents. On the day of audit there were 26 residents. The home is managed by a non-clinical manager who is supported by an experienced registered nurse. Relatives are involved in planning and evaluating care. There is an implemented quality and risk management programme with an internal audit schedule, review of incidents and accidents, management of complaints, and a health and safety programme. There are appropriately skilled staff to support the residents, a comprehensive activities programme provides engaging and appropriate pastimes for the residents.

The service has addressed the six shortfalls identified at the previous certification audit. The following improvements identified at this audit include providing education around challenging behaviours and elder abuse and ensure all employees have an annual appraisal conducted.

Audit Summary as at 5 March 2014

Standards have been assessed and summarised below:

Key

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

Indicator	Description	Definition
	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

Consumer Rights as at 5 March 2014

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.
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Organisational Management as at 5 March 2014

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.
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Continuum of Service Delivery as at 5 March 2014

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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Safe and Appropriate Environment as at 5 March 2014

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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Restraint Minimisation and Safe Practice as at 5 March 2014

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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Infection Prevention and Control as at 5 March 2014

<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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HealthCERT Aged Residential Care Audit Report (version 4.0)

Introduction

This report records the results of an audit against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) of an aged residential care service provider. The audit has been conducted by an auditing agency designated under 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).

It is important that auditors restrict their editing to the content controls in the document and do not delete any content controls or any text outside the content controls.

Audit Report

Legal entity name:	Elsdon Enterprises Limited
Certificate name:	Elsdon Enterprises Limited - Bradford Manor
Designated Auditing Agency:	Health and Disability Auditing New Zealand Limited
Types of audit:	Surveillance Audit
Premises audited:	Bradford Manor
Services audited:	Rest home care – Dedicated dementia care
Dates of audit:	Start date: 5 March 2014 End date: 5 March 2014
Proposed changes to current services (if any):	
Total beds occupied across all premises included in the audit on the first day of the audit:	26

Audit Team

Lead Auditor	XXXXX	Hours on site	8	Hours off site	5
Other Auditors		Total hours on site		Total hours off site	
Technical Experts		Total hours on site		Total hours off site	
Consumer Auditors		Total hours on site		Total hours off site	
Peer Reviewer	XXXXX			Hours	1

Sample Totals

Total audit hours on site	8	Total audit hours off site	6	Total audit hours	14
Number of residents interviewed	0	Number of staff interviewed	5	Number of managers interviewed	0
Number of residents' records reviewed	5	Number of staff records reviewed	4	Total number of managers (headcount)	1
Number of medication records reviewed	10	Total number of staff (headcount)	25	Number of relatives interviewed	1
Number of residents' records reviewed using tracer methodology	1			Number of GPs interviewed	1

Declaration

I, XXXXX, Director of Christchurch hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Act.

I confirm that:

a)	I am a delegated authority of Health and Disability Auditing New Zealand Limited	Yes
b)	Health and Disability Auditing New Zealand Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise	Yes
c)	Health and Disability Auditing New Zealand Limited has developed the audit summary in this audit report in consultation with the provider	Yes
d)	this audit report has been approved by the lead auditor named above	Yes
e)	the peer reviewer named above has completed the peer review process in accordance with the DAA Handbook	Yes
f)	if this audit was unannounced, no member of the audit team has disclosed the timing of the audit to the provider	Yes
g)	Health and Disability Auditing New Zealand Limited has provided all the information that is relevant to the audit	Yes
h)	Health and Disability Auditing New Zealand Limited has finished editing the document.	Yes

Dated Wednesday, 19 March 2014

Executive Summary of Audit

General Overview

Bradford Manor provides dementia level care for up to 26 residents. On the day of audit there were 26 residents. The home is managed by a non-clinical manager (absent on the day of audit), who is supported by an experienced registered nurse. Relatives are involved in planning and evaluating care. There is an implemented quality and risk management programme with an internal audit schedule, review of incidents and accidents, management of complaints, and a health and safety programme. There is appropriately skilled staff to support the residents, a comprehensive activities programme provides engaging and appropriate pastimes for the residents.

The service has addressed the previous six shortfalls identified at the previous certification audit. The following improvements identified at this audit include providing education around challenging behaviours and elder abuse and ensure all employees have an annual appraisal conducted.

Outcome 1.1: Consumer Rights

The service has an open disclosure policy stating residents and/or their representatives have a right to full and frank information and open disclosure from service providers. There is a complaints policy and an incident/accident reporting policy. Family members are informed in a timely manner when their family members' health status changes, education on informed consent has been provided. A complaints register is maintained and shows investigation of all complaints, dates and actions taken for resolution.

Outcome 1.2: Organisational Management

Bradford Manor has a quality and risk management system in place that is implemented and monitored, which generates improvements in practice and service delivery. Key components of the quality management system link to the quality/staff meeting. The service is active in analysing data with corrective actions identified and implemented. The service has addressed and monitored previous finding relating to maintaining up to date policy manuals. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and appropriately managed. There is a comprehensive orientation programme that provides new staff with relevant and specific information for safe work practice. The in-service education programme covers relevant aspects of care and support with the exception of provision of challenging behaviour management and elder abuse. Improvements are required in this area. Staff files evidence appropriate employment documentation. Improvements are required whereby all employees have annual appraisals conducted. The staffing levels provide sufficient and appropriate coverage for the effective delivery of care and support. Staffing is based on the occupancy and acuity of the residents.

Outcome 1.3: Continuum of Service Delivery

The registered nurse and care staff at Bradford Manor are responsible for each stage of service provision. A care plan is developed in consultation with the resident and family/whanau where appropriate. Service delivery plans are individualised, up-to-date and reflect current service delivery requirements for each resident. The plans are reviewed at least six monthly or more frequently if resident's needs change. Short term care plans are utilised for changes in health

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	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			
HDS(C)S.2008	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	(a)It is noted on education records reviewed for 2013 and 2012 that challenging behaviour management and elder abuse has not been provided in the past two years; (b) annual staff appraisals have not been completed in two of four staff files reviewed – registered nurse (last completed February 2012) and one care giver (last completed June 2011).	(a)Provide evidence that challenging behaviour training and elder abuse training has been provided; (b) ensure all employees have annual appraisals conducted.	90

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

NZS 8134.1:2008: Health and Disability Services (Core) Standards

Outcome 1.1: Consumer Rights

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, facilitates informed choice, minimises harm, and acknowledges cultural and individual values and beliefs.

Standard 1.1.9: Communication (HDS(C)S.2008:1.1.9)

Service providers communicate effectively with consumers and provide an environment conducive to effective communication.

ARC A13.1; A13.2; A14.1; D11.3; D12.1; D12.3a; D12.4; D12.5; D16.1b.ii; D16.4b; D16.5e.iii; D20.3 ARHSS A13.1; A13.2; A14.1; D11.3; D12.1; D12.3a; D12.4; D12.5; D16.1bii; D16.4b; D16.53i.i.3.iii; D20.3

Attainment and Risk: FA

Evidence:

<p>The service has an open disclosure policy stating residents and their representatives have a right to full and frank information and open disclosure from service providers. There is a complaints policy and an incident/accident reporting policy. One family member stated they were welcomed on entry and were given appropriate time and explanation about services and procedures. Relative's survey is conducted once a year. Relatives are advised of incidents and accidents and this is recorded in progress notes and in the record of family contact. Other contacts occur when there are changes to medications and in the health status of residents. Advised by the registered nurse that they have an open-door policy. Interpreter services are accessible via the local DHB.</p> <p>D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health "Long-term Residential Care in a Rest Home or Hospital – what you need to know" is provided to residents on entry</p> <p>D16.1b.ii The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.</p> <p>D16.4b One relatives stated that they are always informed when their family members health status changes.</p> <p>D11.3 The information pack is available in large print and advised that this can be read to residents if required.</p>

Criterion 1.1.9.1 (HDS(C)S.2008:1.1.9.1)

Consumers have a right to full and frank information and open disclosure from service providers.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.1.9.4 (HDS(C)S.2008:1.1.9.4)

Wherever necessary and reasonably practicable, interpreter services are provided.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.1.13: Complaints Management (HDS(C)S.2008:1.1.13)

The right of the consumer to make a complaint is understood, respected, and upheld.

ARC D6.2; D13.3h; E4.1biii.3 ARHSS D6.2; D13.3g

Attainment and Risk: FA
Evidence: <p>Complaint forms and a copy of the complaints process is available in the reception area. A complaints register is maintained and shows investigation of all complaints, dates and actions taken for resolution. A complaints folder is maintained and all individual complaints (written and verbal) are documented. There were two complaints for 2013 and no complaints for the year to date. A complaint received in 2013 via the DHB has been managed and resolved. All of the complaints evidenced appropriate documentation and management. Complaints are signed off. The complaints folder and register is kept up to date with evidence of follow up and resolution. Two care givers and one registered nurse confirm that all complaints are reported and recorded. The complaints register is included in the complaints, compliments, incident monthly analysis. All complaints, with corrective actions and outcomes are included in the quality analysis and reported to quality/staff meetings. Relative satisfaction survey is conducted annually with all families invited to participate. Family surveyed advised that they were more than satisfied with the care and services they receive.</p> <p>D13.3h. a complaints procedure is provided to residents within the information pack at entry</p> <p>E4.1biii. There is written information on the service philosophy and practices particular to the Unit included in the information pack including (but not limited to): a) the need for a safe environment for self and others; b) how behaviours different from other Residents are managed and c) specifically designed and flexible programmes, with</p>

emphasis on:

1. Minimising restraint.
2. Behaviour management.
3. Complaint policy.

Criterion 1.1.13.1 (HDS(C)S.2008:1.1.13.1)

The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.1.13.3 (HDS(C)S.2008:1.1.13.3)

An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Outcome 1.2: Organisational Management

Consumers receive services that comply with legislation and are managed in a safe, efficient, and effective manner.

Standard 1.2.1: Governance (HDS(C)S.2008:1.2.1)

The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.

ARC A2.1; A18.1; A27.1; A30.1; D5.1; D5.2; D5.3; D17.3d; D17.4b; D17.5; E1.1; E2.1 ARHSS A2.1; A18.1; A27.1; A30.1; D5.1; D5.2; D5.3; D17.5

Attainment and Risk: FA

Evidence:

Bradford Manor provides dementia specific care for up to 26 residents with 26 residents on the day of audit. There are no respite residents. A non-clinical manager is responsible for day to day running of the home (absent on the day of audit), with clinical oversight provided by a registered nurse. Bradford Manor has a quality assurance and risk management programme in place. There is a business plan for 2012 -2014 that includes a mission statement and operational objectives. There is a risk management schedule and documented quality objectives that align with the identified values and philosophy. An annual review of the quality programme is conducted by the manager. Objectives are reviewed at the quality/staff monthly meetings. There is an internal audit plan. Audits include a summary, any issues arising and corrective actions when required. These are followed through in the monthly quality/staff meetings which incorporate management, quality improvement, infection control, health and safety and restraint. Resident and family satisfaction is gauged through an open door policy, annual relative's survey, complaints, compliments and suggestions.

The manager has maintained at least eight hours annually of professional development activities related to managing a rest home. She has attended local provider meetings, attended a human resource management session and attends all in-service sessions at Bradford Manor.

Criterion 1.2.1.1 (HDS(C)S.2008:1.2.1.1)

The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.2.1.3 (HDS(C)S.2008:1.2.1.3)

The organisation is managed by a suitably qualified and/or experienced person with authority, accountability, and responsibility for the provision of services.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.2.3: Quality And Risk Management Systems (HDS(C)S.2008:1.2.3)

The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.

ARC A4.1; D1.1; D1.2; D5.4; D10.1; D17.7a; D17.7b; D17.7e; D19.1b; D19.2; D19.3a.i-v; D19.4; D19.5 ARHSS A4.1; D1.1; D1.2; D5.4; D10.1; D16.6; D17.10a; D17.10b; D17.10e; D19.1b; D19.2; D19.3a-iv; D19.4; D19.5

Attainment and Risk: FA
Evidence: <p>The service has a quality assurance and risk management programme which is designed to monitor contractual and standards compliance and the quality of service delivery. There is a strategic plan for 2012 - 2014 and a current quality and risk management plan. Quality goals include client focused services, high standard of services, orientation for all new staff, education for staff, a homely atmosphere for staff, promoting safe resident independence, involvement of family, and efficient use of resources. The monthly quality/staff meetings reflect the service's commitment to continuous quality improvement, there is an internal audit schedule in place. There is evidence of the regular monitoring of a wide variety of aspects of the service via this internal audit schedule, the education planner and meeting planner. Feedback and progress relating to quality and risk management systems is provided during quality/staff meetings and to the owners via the manager. The quality/staff meeting includes (but is not limited to) feedback pertaining to: internal audits; quality initiatives; satisfaction surveys; complaints; incident and accident analysis; infection control analysis; restraint; and education. Minutes are maintained and easily available to staff in the office (minutes sighted for January 2014). Minutes include actions to achieve compliance where relevant. This, together with staff training, demonstrates Bradford Manor's commitment to on-going quality improvement. Discussions with one registered nurse (RN), and two caregivers confirm their involvement in the quality programme. Resident/relative meetings no longer take place as attendance was minimal. Discussions are held with residents and families on a regular but informal basis. Emergent issues are dealt with promptly as advised by the registered nurse and one family member. Due to the small size of the service, residents and family members are able to discuss any issues or matters of concern with management on a daily basis.</p> <p>D5.4 The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards including those standards relating to the Health and Disability Services (Safety) Act 2001. The content of policy and procedures is detailed to allow effective implementation by staff. The reviews of the policies and procedures are scheduled to be completed on bi-annual basis and is discussed at quality/staff</p>

meetings.

The service has a health and safety management system and this includes the identification of a health and safety officer. Security and safety policies and procedures are in place to ensure a safe environment is provided. Emergency plans ensure appropriate response in an emergency. Health and safety is discussed at management meetings and includes hazard management, falls and incidents, and hazard identification.

There is a comprehensive infection control manual. There is a restraint policy and health and safety policies and procedures.

There is an annual staff training programme that is implemented that is based around policies and procedures. Records of staff attendance are maintained.

A document control system is in place. Documents no longer relevant to the service are removed and archived. Policies and procedures that are updated are documented on a document control sheet that is held in the front of each policy manual. The registered nurse reports staff are made aware of policy updates via staff meetings and copies of policy updates are posted in the nurse's station. Staff sign to acknowledge that they have read any new or updated policies. The service has addressed the previous audit finding relating to maintaining up to date policy manuals.

The service collects information on resident incidents and accidents, and staff incidents/accidents. Incident/accident forms are completed and given to the registered nurse who completes the follow up. All incident/accident forms are seen by the manager. The manager completes any additional follow up and collates and analyses data to identify trends.

Complaints/concerns are recorded on a complaints register. There is evidence that complaints/concerns are followed up and any concerns raised through surveys are followed up and actioned.

Infection control data is collated monthly and reported to staff. One registered nurse and two caregivers interviewed are well informed about infection control.

Actual and potential risks are identified and corrective actions initiated. There is a hazard register that includes type, potential harm, action to minimise, control measures and checks. The hazard register is reviewed annually.

Results of internal audits, reports from incidents and accidents, infection rates, restraint use and health and safety issues are discussed with staff through the monthly quality/staff meetings. This meeting incorporates discussion around health and safety, resident issues, infection control, education and quality assurance. Staff are able to contribute to the staff meeting agenda. A handover folder also records infections and resident issues.

A process is implemented to measure achievement against goals in the strategic plan and quality improvement plan. Formal review takes place annually. Internal audits are completed and include the identification of any issues and corrective actions where required. Internal audits conducted for 2013 included health and safety, kitchen, laundry, cleaning, privacy, care plans and medication. Incidents, accidents, hazards, complaints, infections and restraint/enablers are monitored. Annual relative satisfaction surveys are conducted (last conducted 2013). The survey attracted a 57% return rate with all respondents stating that that they were very happy with the care provided and overall quality of the service.

Criterion 1.2.3.1 (HDS(C)S.2008:1.2.3.1)

The organisation has a quality and risk management system which is understood and implemented by service providers.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.3.3 (HDS(C)S.2008:1.2.3.3)

The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.3.4 (HDS(C)S.2008:1.2.3.4)

There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.3.5 (HDS(C)S.2008:1.2.3.5)

Key components of service delivery shall be explicitly linked to the quality management system.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.3.6 (HDS(C)S.2008:1.2.3.6)

Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.3.7 (HDS(C)S.2008:1.2.3.7)

A process to measure achievement against the quality and risk management plan is implemented.

Attainment and Risk: FA
Evidence:

Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.3.8 (HDS(C)S.2008:1.2.3.8)

A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.3.9 (HDS(C)S.2008:1.2.3.9)

Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:

- (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;
- (b) A process that addresses/treats the risks associated with service provision is developed and implemented.

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.2.4: Adverse Event Reporting (HDS(C)S.2008:1.2.4)

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.

ARC D19.3a.vi.; D19.3b; D19.3c ARHSS D19.3a.vi.; D19.3b; D19.3c

Attainment and Risk: FA

Evidence:

Discussions with the registered nurse confirms her awareness of the requirement to notify relevant authorities in relation to essential notifications.
D19.3c The service is aware that they will inform the DHB of any serious accidents or incidents.

The service documents and analyses incidents, accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Individual incident/accident reports are completed for each incident/accident by the individual witnessing the event, with immediate action noted by the care staff on duty. The registered nurse follows up on any clinical issues or care staff instigate referral to the general practitioner or emergency services if required. A monthly review of all reports is conducted and an annual review is also compiled and completed for 2013. A review of a sample of incident reports for February 2014 involved two residents. One resident had two reports of aggressive behaviours and one resident had one report of aggressive behaviours and three falls. Appropriate clinical response has been conducted with risk assessments, referral to nurse practitioner for advice and assistance and medication reviews conducted. Referral to needs assessment team has been instigated for three residents (including one with incident reports for February 2014) – in response to incidents and higher acuity. The manager signs off on all adverse events. Minutes of the quality/staff meetings reflect a discussion of incidents/accidents and actions taken. Accident and incident forms, and records in the resident file including progress notes, provide evidence that families are kept informed - and confirmed on family interview.

Criterion 1.2.4.2 (HDS(C)S.2008:1.2.4.2)

The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.4.3 (HDS(C)S.2008:1.2.4.3)

The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.2.7: Human Resource Management (HDS(C)S.2008:1.2.7)

Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.

ARC D17.6; D17.7; D17.8; E4.5d; E4.5e; E4.5f; E4.5g; E4.5h ARHSS D17.7, D17.9, D17.10, D17.11

Attainment and Risk: PA Low
Evidence: Bradford Manor employs 25 permanent staff. The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates including registered nurse and general practitioners is kept. There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Four staff files were reviewed (one registered nurse and three caregivers). Reference checks are completed before employment is offered and are evident in employee files reviewed. Signed employment contracts are held on file. Position descriptions are evident in the four files reviewed. Police vetting is not routinely conducted. The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Two caregivers were able to describe the orientation process and stated that new staff are adequately orientated to the service. Additional time is allocated by the manager for staff who require additional training. Orientation programmes are specific to the service type (eg, RN, caregiver, cleaner). Completed orientation checklists are held in staff files (sighted in all four staff files audited). Discussion with one registered nurse, and two caregivers confirm that a comprehensive in-service training programme is in place that covers relevant aspects of care and

support and meets requirements. There is completed education plan for 2013 with records maintained for content and attendance. The annual training programme exceeds eight hours annually. Additionally, all caregivers are required to undertake aged care education within six months of commencement of employment. Two caregivers interviewed have both completed the National Certificate in care of the elderly including dementia unit standards. Of the 15 care givers employed, 11 have completed the dementia unit standards, two are in the process of completing and two have yet to start (commenced employment within the past six months). Education in 2013 included but not limited to: manual handling, restraint, medication management, food handling, informed consent and code of rights, infection control, safe chemical handling, fire safety, civil defence, and cultural awareness. It is noted on education records reviewed for 2013 and 2012 that challenging behaviour management and elder abuse has not been provided in the past two years. Improvements are required in this area. Medication education and competencies completed in 2013 for care staff who administer medications. All care staff have completed first aid training. Education sessions are combined with staff meetings to ensure maximum staff attendance. Education records are maintained and are up to date. The manager maintains comprehensive staff records to identify training needs and attendance. Annual staff appraisals have been completed in two of four staff files reviewed. Improvements are required in this area.

Criterion 1.2.7.2 (HDS(C)S.2008:1.2.7.2)

Professional qualifications are validated, including evidence of registration and scope of practice for service providers.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.2.7.3 (HDS(C)S.2008:1.2.7.3)

The appointment of appropriate service providers to safely meet the needs of consumers.

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.7.4 (HDS(C)S.2008:1.2.7.4)

New service providers receive an orientation/induction programme that covers the essential components of the service provided.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.7.5 (HDS(C)S.2008:1.2.7.5)

A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.

Attainment and Risk: PA Low
Evidence: <p>Discussion with one registered nurse, and two caregivers confirm that a comprehensive in-service training programme is in place that covers relevant aspects of care and support and meets requirements. There is completed education plan for 2013 with records maintained for content and attendance. The annual training programme exceeds eight hours annually. Additionally, all caregivers are required to undertake aged care education within six months of commencement of employment. Two caregivers interviewed have both completed the National Certificate in care of the elderly including dementia unit standards. Of the 15 care givers employed, 11 have completed the dementia unit standards, two are in the process of completing and two have yet to start (commenced employment within the past six months). Education in 2013 included but not limited to: manual handling, restraint, medication management, food handling, informed consent and code of rights, infection control, safe chemical handling, fire safety, civil defence, and cultural awareness. Advised by the registered nurse that discussions with staff occur around management of individual behaviours and care plans reviewed reflect comprehensive behaviour management plans. Medication education and competencies completed in 2013 for care staff who administer medications. All care staff have completed first aid training. Education sessions are combined with staff meetings to ensure maximum staff attendance. Education records are maintained and are up to date. The manager maintains comprehensive staff records to identify training needs and attendance. Annual staff appraisals have been completed in two of four staff files reviewed.</p>

Finding:

(a) It is noted on education records reviewed for 2013 and 2012 that challenging behaviour management and elder abuse has not been provided in the past two years; (b) annual staff appraisals have not been completed in two of four staff files reviewed – registered nurse (last completed February 2012) and one care giver (last completed June 2011).

Corrective Action:

(a) Provide evidence that challenging behaviour training and elder abuse training has been provided; (b) ensure all employees have annual appraisals conducted.

Timeframe (days): 90 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.2.8: Service Provider Availability (HDS(C)S.2008:1.2.8)

Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.

ARC D17.1; D17.3a; D17.3 b; D17.3c; D17.3e; D17.3f; D17.3g; D17.4a; D17.4c; D17.4d; E4.5 a; E4.5 b; E4.5c ARHSS D17.1; D17.3; D17.4; D17.6; D17.8

Attainment and Risk: FA**Evidence:**

There is a staff numbers and skill mix policy that is sufficiently detailed to ensure that there is appropriate staff to safely meet the needs of consumers. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support.

Interviews with one registered nurse, two caregivers, and one family member identify that staffing is adequate to meet the needs of residents.

The manager works full-time. The registered nurse works 35 hours per week. Senior caregivers provide on call for non-clinical matters (staffing and rosters), with the registered nurse providing on-call for urgent clinical matters.

The roster includes the at least two care givers on duty on each shift. Care givers attend to residents' laundry. The kitchen is staffed by a kitchen hand/cleaner. Staff numbers are adjusted based on resident acuity and the occupancy rate.

Criterion 1.2.8.1 (HDS(C)S.2008:1.2.8.1)

There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.

Attainment and Risk: FA**Evidence:****Finding:****Corrective Action:**

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Outcome 1.3: Continuum of Service Delivery

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.

Standard 1.3.3: Service Provision Requirements (HDS(C)S.2008:1.3.3)

Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals.

ARC D3.1c; D9.1; D9.2; D16.3a; D16.3e; D16.3l; D16.5b; D16.5c; D16.5c.ii; D16.5e ARHSS D3.1c; D9.1; D9.2; D16.3a; D16.3d; D16.5b; D16.5d; D16.5e; D16.5i

Attainment and Risk: FA

Evidence:

The registered nurse has been in the role for three years and is responsible for undertaking the assessments on admission, with the initial support plan completed within 24 hours of admission as evidenced in five of five resident files reviewed. The nursing care assessments and long term care plans are completed within three weeks and align with the service delivery policy. Five files were reviewed with five of five long term care plans completed within the three week time frame and appropriate assessments have been completed for all identified issues. Care plan evaluations are conducted within specified time frames.

Wound care assessments and treatment plans are available. There are currently no residents with wounds. Short term care plans are developed for wound management, infections, skin tears, behaviours and pain. A diversional therapy plan is used for activities with an activities assessments, client profile, activities records and six monthly evaluations completed by the two diversional therapists.

The registered nurse is familiar with the timeframes and files reviewed were kept up to date. InterRAI assessment tool has yet to be utilised. The registered nurse advised that she is booked in to attend InterRAI training in July 2014.

D16.2, 3, 4; An assessment and initial care plan is completed within 24 hours for one new admission. A long term care plan is developed, and reviewed by the registered nurse and amended when current health changes. Evaluation is completed within six months for four of five care plans reviewed - one resident admitted within the past six months.

D16.5e; Medical assessments were documented in five of five long term files reviewed within two working days of admission. Three monthly medical reviews were documented in all five files by a general practitioner. It was noted in all five resident files reviewed, identified that the GP has assessed the resident as stable and is to be seen three monthly. On interview the GP advised that residents are seen three monthly or more frequently if required. More frequent medical assessment/ review noted occurring in residents with acute conditions.

Assessment tools available for completion on admission include a comprehensive nursing assessment as well as: a) pressure area risk assessment, b) pain assessment and pain charts, c) challenging behaviours and monitoring forms, d) continence assessment, e) falls risk, f) nutritional assessment. Assessments are reviewed when there is a change to condition or at least six monthly.

Staff could describe a verbal handover at the end of each duty that maintains a continuity of service delivery. On interview, the GP (with majority of residents) advised that he visits the service weekly. Progress notes are maintained. Progress notes are written at least daily or more frequently as required. Five files reviewed evidence this is occurring. The GP interviewed also stated that the service is prompt at informing of changes in the residents conditions and that instructions are carried out.

Tracer Methodology:

XXXXXX This information has been deleted as it is specific to the health care of a resident.

Criterion 1.3.3.1 (HDS(C)S.2008:1.3.3.1)

Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.3.3 (HDS(C)S.2008:1.3.3.3)

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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.3.4 (HDS(C)S.2008:1.3.3.4)

The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.3.6: Service Delivery/Interventions (HDS(C)S.2008:1.3.6)

Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.

ARC D16.1a; D16.1b.i; D16.5a; D18.3; D18.4; E4.4 ARHSS D16.1a; D16.1b.i; D16.5a; D16.5c; D16.5f; D16.5g.i; D16.6; D18.3; D18.4

Attainment and Risk: FA
Evidence: <p>Five resident files were reviewed. Care plans are individualised and personalised to reflect needs, goals and outcomes in the long term care plan in five of five files reviewed. Each aspect of the long term care plan includes a goal, interventions and evaluations. Long term care plans have all care issues recorded under headings relating to safety and risk, personal care and hygiene, elimination, nutrition, mobility, social, spiritual and cultural, medications, pain management, rest and sleep, communication, and behaviours. Care plans were current and interventions reflect the assessments conducted and the identified requirements of the residents in five of five files reviewed. Interview with one registered nurse verified involvement of families in the care planning process. There were short term care plans in three of five files reviewed and include plans for infections, changes in health status, pain and behaviour management. One resident with an infection demonstrate a link between short term care planning and infection prevention and control management plan.</p> <p>D18.3 and 4 Dressing supplies are available and a nurse's station/treatment room is stocked for use.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management.</p> <p>Specialist continence advice is available as needed and this could be described.</p> <p>Continence management in-services and wound management in-service have been provided.</p> <p>A nurse practitioner experienced in dementia and challenging behaviour management is available to the service and visits residents on a regular basis.</p>

Criterion 1.3.6.1 (HDS(C)S.2008:1.3.6.1)

The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.3.7: Planned Activities (HDS(C)S.2008:1.3.7)

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.

ARC D16.5c.iii; D16.5d ARHSS D16.5g.iii; D16.5g.iv; D16.5h

Attainment and Risk: FA
Evidence:
<p>There are two diversional therapists (DT) who cover Monday to Sunday. One DT works for 30 hours per week from Monday to Friday and one DT works for 12 hours per week Saturday and Sunday. The programme is planned monthly and residents and family have input in to what activities are provided. Individual and group activities are catered for. Activities planned for the day are posted on a white board in the home.</p> <p>A resident profile and diversional therapy assessment is completed on admission which forms the basis for the diversional therapy plan. The plan includes goals and ambitions as well as a plan of meaningful activities. The resident is encouraged to join in activities that are appropriate and meaningful. There is an activities section in the resident file that include an activities documentation. The programme is evaluated and can be individually tailored according to resident's needs.</p> <p>The registered nurse advised that residents assessed prior to participating in community activities – either in the company of family or staff.</p> <p>Activities provided include (but not limited to): outings in the facility van, exercises, music, art, crafts, visiting entertainment, church services and hymn singing, quizzes and word finding games, newspaper reading, chat groups, reminiscing, seasonal celebrations, and individual one to one time. Residents were observed participating in balloon tennis, and a church service. Resident/relative meetings are no longer held due at poor attendance. Annual relative survey in conducted to gauge satisfaction with the activities programme. One family member interviewed discussed enjoyment in the programme and the diversity offered to all residents.</p> <p>D16.5d Resident files reviewed identified that the individual activity plan is reviewed when at care plan review.</p>

Criterion 1.3.7.1 (HDS(C)S.2008:1.3.7.1)

Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.3.8: Evaluation (HDS(C)S.2008:1.3.8)

Consumers' service delivery plans are evaluated in a comprehensive and timely manner.

ARC D16.3c; D16.3d; D16.4a ARHSS D16.3c; D16.4a

Attainment and Risk: FA
Evidence: Four of five care plans reviewed evidenced that the overall care plan evaluations are comprehensive, relate to each aspect of the long term care plan and record the degree of achievement of goals and interventions (one resident has been at Bradford Manor for three months and the care plan is not yet due for evaluation). Care plans reviewed are updated as changes are noted in care requirements. Short term care plans are well utilised for residents. Any changes to the long term care plan are dated and signed. Four of five care plans reviewed included handwritten updates to the plan as needs have changed for certain aspects of the plan. Short term care plans were sighted for wounds, infections, pain management, and short term health issues. D16.4a Care plans are evaluated six monthly more frequently when clinically indicated with exceptions. D16.3c: All initial care plans were developed with 24 hours of admission and evaluated by the RN within three weeks of admission.

Criterion 1.3.8.2 (HDS(C)S.2008:1.3.8.2)

Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.

Attainment and Risk: FA
Evidence:

Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.3.8.3 (HDS(C)S.2008:1.3.8.3)

Where progress is different from expected, the service responds by initiating changes to the service delivery plan.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.3.12: Medicine Management (HDS(C)S.2008:1.3.12)

Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.

ARC D1.1g; D15.3c; D16.5e.i.2; D18.2; D19.2d ARHSS D1.1g; D15.3g; D16.5i..i.2; D18.2; D19.2d

Attainment and Risk: FA
Evidence: <p>The service uses individualised medication blister packs. The medications are delivered monthly and checked in by the registered nurse or a senior medication competent care giver. Medication charts record prescribed medications by residents' general practitioner (GP), including PRN and short course medications. A care giver was observed administering medications to the residents at a lunch time medication round, and followed correct administration procedures. Advised that this new role has been introduced so that one care giver is responsible for the medication rounds only – this is a split shift and the staff member administers breakfast, lunch and evening medications. The service has made improvements in this area. Medications and associated documentation is kept on the medication trolley in the locked treatment room/nurses station. The service has addressed and monitored this previous finding. Medications are reviewed three monthly with medical reviews by the attending GP. Documentation of reviews is included in medical file section of resident integrated files and on the drug charts. No evidence of transcribing on 10 of 10 medication administration signing sheets or on five of five care plans reviewed and signing sheets were completed appropriately. The service has addressed and monitored these</p>

previous findings.

Controlled drugs are stored in one locked safe and cupboard inside the locked treatment room. Controlled drugs are recorded and checked by two staff members in the controlled drug register. One resident has a PRN controlled drug prescribed and weekly checks are conducted. The medication fridge is monitored and recorded daily. The service has addressed and monitored this previous finding.

Medication reconciliation is completed on admission and the policy includes guidelines on checking on arrival. Resident photos and allergies (or nil known allergies) are recorded on all 10 drug charts reviewed. An annual medication administration competency is completed by the registered nurse for those care givers who have the responsibility of administering medications. There are no residents self-medicating. Individually prescribed resident medication charts are in use and this provides a record of medication administration information that complies with relevant recording requirements. The service has in place policies and procedures for ensuring all medicine related recording and documentation is: a) legible, b) signed and dated and c) able to meet acceptable good practice standards. As required medication orders (PRN) all record indications for use. Advised by the RN that no PRN medication is given by caregivers without authorisation from the registered nurse. Behaviour management plans in five of five care plans reviewed evidence comprehensive behaviour management strategies with PRN medication to only use as a last resort. D16.5.e.i.2; Ten of ten medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed.

Criterion 1.3.12.1 (HDS(C)S.2008:1.3.12.1)

A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.3.12.3 (HDS(C)S.2008:1.3.12.3)

Service providers responsible for medicine management are competent to perform the function for each stage they manage.

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.3.12.5 (HDS(C)S.2008:1.3.12.5)

The facilitation of safe self-administration of medicines by consumers where appropriate.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.3.12.6 (HDS(C)S.2008:1.3.12.6)

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.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.3.13: Nutrition, Safe Food, And Fluid Management (HDS(C)S.2008:1.3.13)

A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.

ARC D1.1a; D15.2b; D19.2c; E3.3f ARHSS D1.1a; D15.2b; D15.2f; D19.2c

Attainment and Risk: FA

Evidence:

All meals are prepared and cooked by ACE food services and deliveries are made to Bradford Manor three times per day. Food is transported in hot boxes. A kitchen hand prepares the breakfast meal and has completed safe food handling in November 2012. The service has made improvements in this area. A four weekly seasonal menu has been developed and reviewed by a registered dietitian. The kitchen is of appropriate size and includes a free standing range with cook top, fridge, freezer, small pantry and store room. Resident's dietary requirements are catered for including pureed, vegetarian, gluten free, diabetic and soft. No residents are receiving supplements.

A dietary requirements form and nutritional assessment is conducted on admission and as changes occur. Food is served directly from the kitchen Bain Marie to the dining room.

The kitchen hand advised that the fridge and freezer temperatures are visually checked daily and the manager records these on a monthly basis. Records reviewed for the previous three months evidenced that temperatures are all within acceptable limits. Food stored in the fridge and freezer is covered and labelled with a day of the week sticker. Advised that left over food is stored for 48 hours then discarded. The kitchen has a pantry with extra food stores - enough for three days if required in an emergency.

A registered nurse conducts nutritional assessments on all residents and develops nutritional plans for residents with identified weight issues. There is currently one resident with weight loss which has been attributed to fluid medication. Weights reviewed are stable for the remaining four of five files reviewed. Dietary information is documented in the long term care plan if there is an identified nutritional issue.

Resident weights are monitored monthly or more frequently if required.

Relative satisfaction survey which includes food and meal service, was conducted in 2013. The lunch time meal service was observed with care staff providing assistance to those residents who require it.

Criterion 1.3.13.1 (HDS(C)S.2008:1.3.13.1)

Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.13.2 (HDS(C)S.2008:1.3.13.2)

Consumers who have additional or modified nutritional requirements or special diets have these needs met.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.13.5 (HDS(C)S.2008:1.3.13.5)

All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Outcome 1.4: Safe and Appropriate Environment

Services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensures 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.

Standard 1.4.2: Facility Specifications (HDS(C)S.2008:1.4.2)

Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.

ARC D4.1b; D15.1; D15.2a; D15.2e; D15.3; D20.2; D20.3; D20.4; E3.2; E3.3e; E3.4a; E3.4c; E3.4d ARHSS D4.1c; D15.1; D15.2a; D15.2e; D15.2g; D15.3a; D15.3b; D15.3c; D15.3e; D15.3f; D15.3g; D15.3h; D15.3i; D20.2; D20.3; D20.4

Attainment and Risk: FA

Evidence:

The service displays a current building warrant of fitness which expires on 20 December 2014.

Criterion 1.4.2.1 (HDS(C)S.2008:1.4.2.1)

All buildings, plant, and equipment comply with legislation.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

NZS 8134.2:2008: Health and Disability Services (Restraint Minimisation and Safe Practice) Standards

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

Standard 2.1.1: Restraint minimisation (HDS(RMSP)S.2008:2.1.1)

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Attainment and Risk: FA

Evidence:

Restraint minimisation is overseen by a restraint coordinator who is the registered nurse. There is currently one resident identified as requiring restraint and no enablers. On review of the resident's file, the RN has completed a restraint assessment for a lap belt and bed rails. This was instigated in July 2013 after discussion with family and GP. Consent, restraint care plan and review is completed. Hourly monitoring for both types of restraint is conducted and recorded. The registered nurse conducts a monthly review of the restraint in use and the restraint committee met last in February 2014 to review the restraint use. A restraint register is maintained. Policy states that the use of enablers is voluntary and is requested by the resident. Restraint/enabler training is included in the in-service training plan – last provided in September 2013. Challenging behaviour in-service has not been provided in the past two years (link #1.2.7.5)

Criterion 2.1.1.4 (HDS(RMSP)S.2008:2.1.1.4)

The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

NZS 8134.3:2008: Health and Disability Services (Infection Prevention and Control) Standards

Standard 3.1: Infection control management (HDS(IPC)S.2008:3.1)

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.

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA
Evidence: Bradford Manor has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system. Policies and procedures are provided and updated by the registered nurse (infection control nurse). Discussion and reporting of infection control matters is conducted at the quality/staff meetings. Regular audits take place that include hand hygiene, infection control practices, laundry and cleaning. Annual education is provided for all staff (May 2013). The annual review of the 2013 programme has been conducted in December 2013. The service has addressed and monitored this previous finding. Hand washing facilities are available for staff, residents and visitors throughout the facility and signs are displayed promoting hand hygiene and warnings to visitors. Alcohol hand gel is also widely available and utilised.

Criterion 3.1.3 (HDS(IPC)S.2008:3.1.3)

The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 3.2: Implementing the infection control programme (HDS(IPC)S.2008:3.2)

There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA
Evidence: The infection control nurse (registered nurse) has been in the role of IC coordinator since commencing employment in 2011 and has completed on-line infection control

training in September 2012, in October 2012 around outbreak management and in January 2014 relating to infections and antibiotic resistance and completed the on-line infection prevention training again. The infection control co-ordinator has good external support from an IC consultant at Dunedin hospital and the expert infection control specialist team at the local laboratory. The infection control team is representative of the facility. The registered nurse is on duty for 35 hours per week and on call at all other times enabling prompt notification of pathology results. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The service has addressed this previous finding.

Criterion 3.2.1 (HDS(IPC)S.2008:3.2.1)

The infection control team/personnel and/or committee shall comprise, or have access to, persons with the range of skills, expertise, and resources necessary to achieve the requirements of this Standard.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 3.4: Education (HDS(IPC)S.2008:3.4)

The organisation provides relevant education on infection control to all service providers, support staff, and consumers.

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

The infection control policy states that the facility is committed to the on-going education of staff and residents. This is facilitated by the infection control nurse. All infection control training is documented and a record of attendance is maintained. Infection control education was provided in May 2012 with 10 attendees. In May 2013 a self-directed learning tool and quiz was completed by staff with feedback provided from the infection control nurse. Evaluations have been completed by staff in relation to this education. The service has made improvements in this area. Infection control education is also provided at the orientation session for new staff and includes hand hygiene. All staff complete an infection control questionnaire. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records. Infection control education also occurs as part of staff meetings, and through hand washing audits.

Criterion 3.4.1 (HDS(IPC)S.2008:3.4.1)

Infection control education is provided by a suitably qualified person who maintains their knowledge of current practice.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 3.5: Surveillance (HDS(IPC)S.2008:3.5)

Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.

Attainment and Risk: FA
Evidence: Infection surveillance is an integral part of the infection control programme and is described in Bradford Manor infection control policy. The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control nurse (RN) uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GP's and laboratory that advise and provide feedback /information to the service. Systems in place are appropriate to the size and complexity of the facility. Monthly infection data is collected for all infections. All infections are entered on to an infection register. This data is monitored, evaluated and monthly graphs are produced. Outcomes and actions are discussed at handover, and at quality/staff meetings. Graphs are displayed in the nurse's station.

Criterion 3.5.1 (HDS(IPC)S.2008:3.5.1)

The organisation, through its infection control committee/infection control expert, determines the type of surveillance required and the frequency with which it is undertaken. This shall be appropriate to the size and complexity of the organisation.

Attainment and Risk: FA
Evidence:

Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 3.5.7 (HDS(IPC)S.2008:3.5.7)

Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>