# Elsdon Enterprises Limited - Bradford Manor

## Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](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:** Elsdon Enterprises Limited

**Premises audited:** Bradford Manor

**Services audited:** Dementia care

**Dates of audit:** Start date: 17 August 2018 End date: 17 August 2018

**Proposed changes to current services (if any):** An activities room has been converted to a resident room and one resident room has been converted to a clinical room that is used for GP and health professional visits.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 23

# 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

Bradford Manor provides dementia level of care for up to 26 residents with 23 residents on the day of audit. The experienced manager is supported by registered nurses and care staff. The service continues to implement a quality and risk management programme. The activities programme is varied and designed to meet the needs of residents.

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

Family/whānau and general practitioner interviewed commented positively on the standard of care and services provided at Bradford Manor rest home.

There is one area of continuous improvement awarded around the activities programme.

## 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. |

Bradford Manor provides care in a way that focuses on the individual resident. Cultural and spiritual assessment is undertaken on admission and during the review processes. Policies are implemented to support individual rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. Information about the Code and related services is readily available to residents and families/whānau. Information on informed consent is included in the admission agreement and discussed with residents and family. Care plans identify the choices of residents and/or their family/whānau. Care plans accommodate the choices of residents and/or their family. Complaints processes are implemented and managed in line with the Code.

## Organisational management

|  |  |  |
| --- | --- | --- |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Standards applicable to this service fully attained. |

Bradford Manor is part of the Elsdon Enterprises Group. The manager is supported by two registered nurses. Bradford Manor has implemented a quality and risk management system that supports the provision of clinical care. Quality data is collated for accident/incidents, infections, internal audits, concerns and complaints and surveys. Incidents and accidents are appropriately managed. There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. There is an education programme covering relevant aspects of care and external training is supported. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

## Continuum of service delivery

|  |  |  |
| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | All standards applicable to this service fully attained with some standards exceeded. |

There is information available for residents and families prior to entry to the service. Residents are assessed prior to entry to the service. Communication with family/whānau is documented. The clinical lead/registered nurse is responsible for each stage of service provision at the facility. Care plans are individually developed with resident and family/whānau involvement included where appropriate, and evaluated six monthly or more frequently when clinically indicated. The interRAI and other risk assessment tools and monitoring forms are available to effectively assess the level of risk and support required for residents. Short-term care plans are in use for changes in health status. Activities are provided that are meaningful and ensure that the resident maintains involvement in the community. Residents have a choice in their level of participation. Activity care plans are documented for all residents and evaluated six-monthly. A medication management system is implemented, and medication management policies are documented. All staff have completed annual competencies for medication administration. There are three monthly GP medication reviews. All food is cooked at Bradford Manor. The menu is designed by a dietitian with four weekly seasonal menus. Staff have completed food safety training. Dietary requirements are provided where cultural and special needs are required.

## Safe and appropriate environment

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

Bradford Manor has a current building warrant of fitness. Reactive and preventative maintenance is carried out. Medical equipment has been calibrated. There is a designated laundry, which includes the safe storage of cleaning and laundry chemicals. Residents’ rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. There are sufficient communal areas within the home that include lounge and dining area, and smaller seating areas. The service has implemented policies and procedures for civil defence and other emergencies and six-monthly fire drills are conducted. There is a call bell system in all areas. General living areas and resident rooms are appropriately heated and ventilated and have good lighting. External garden areas are secure with suitable pathways, seating and shade provided.

## Restraint minimisation and safe practice

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

The service has policies and procedures to appropriately guide staff around the use of enablers or restraints. The clinical lead/registered nurse is the restraint coordinator. There were no residents using enablers or restraints. Staff receive training in restraint and managing challenging behaviour.

## Infection prevention and control

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

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator is the clinical lead/registered nurse. There is a suite of infection control policies and guidelines that meet infection control standards. The infection control programme is reviewed annually. Staff receive annual infection control education. Surveillance is used to determine quality assurance activities and education needs for the facility.

## Summary of attainment

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 1 | 44 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 1 | 92 | 0 | 0 | 0 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](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 | The Code of Health and Disability Services Consumers’ Rights (the Code) policy and procedure is implemented. Discussions with seven staff (two caregivers, one medication administrator, one clinical lead/registered nurse, one diversional therapist, one cook, and one maintenance staff) confirmed their familiarity with the Code and its application to their work. Interviews with four family members confirmed that the services being provided are in line with the Code. This was also confirmed in the resident/family satisfaction survey results (November 2017). |
| 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 | Informed consent and resuscitation orders were appropriately recorded, as evidenced in all six resident files reviewed. Written consents are included within the admission agreement and are signed by the resident or their EPOA. Families interviewed confirmed that information was provided to enable informed choices to be made for their family member. Caregivers interviewed confirmed verbal consent is obtained when delivering care. Resident admission agreements sighted were signed. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Family members are provided with a copy of the Code of Health and Disability Services Consumer Rights and Advocacy pamphlet on admission. Interviews with family confirmed they were aware of their right to access advocacy. Advocacy pamphlets are displayed in the foyer. Resident files reviewed confirmed that the service provides opportunities for the family/EPOA to be involved in decisions. The residents’ files include information on residents’ family/whānau and chosen social networks. |
| 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 | On interview, family members confirmed that they can visit at any time and are encouraged to be involved with the service and care. Residents are facilitated wherever possible and appropriate, to maintain former activities and interests in the community. They are supported to attend family events. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | There is a complaints policy to guide practice, which aligns with Right 10 of the Code. The manager leads the investigation of any concerns/complaints.  A compliments, suggestions and complaints brochure is visibly displayed in the main entrance. There is a suggestions/complaints box. The service has responded appropriately to one complaint lodged in 2018 and two complaints lodged in 2017. Complaints are responded to within the required timeframes as determined by the Health and Disability Commissioner. All three complaints reviewed were documented as resolved.  The complaints process is linked to the quality and risk management system. Staff are kept informed of any complaints received in the quarterly staff meetings. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | There is a welcome pack that includes information about the Code and this is discussed during the admission process with the resident and family. Family members interviewed confirmed they received all the relevant information during admission. The entry pack includes written information on how to make a complaint, a Code of Rights pamphlet, and a brochure explaining advocacy services.  Families are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | There are policies in place to guide practice in respect of independence, privacy and respect. Staff were observed to be respectful of residents’ personal privacy by knocking on doors prior to entering resident rooms during the audit. Family members interviewed confirmed staff respect the resident’s privacy, and supported residents in making choices. Resident files are stored securely. The service has a philosophy focused around promoting quality of life, involving residents in decisions about their care, respects their rights and maintains privacy and individuality. Residents’ preferences are identified during the admission and care planning process with resident/family involvement. Six resident files reviewed identified that cultural and/or spiritual values and individual preferences are identified on admission and are integrated with the resident’s care plan. |
| 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 | Bradford Manor has a Māori health plan that includes a description of how they will achieve the requirements set out in A3.1 (a) to (e).  There is a cultural safety policy to guide practice, including recognition of Māori values and beliefs and culturally safe practices for Māori. Staff interviewed were able to describe how they would ensure Māori values and beliefs are met. Staff attend cultural safety and awareness training with the last in-service 26 October 2017. A kapa haka group from the local area will be providing entertainment for the residents later in the month.  There were two residents living at the facility who identified as Māori. One Māori family member interviewed reported that their whānau’s cultural needs and values were being met by the service. |
| 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 | Family are invited to be involved in care planning and any beliefs or values are further discussed and incorporated into the care plan. Residents’ care plans reviewed included the residents’ social, spiritual, cultural and recreational needs. Six monthly reviews occur to assess if the residents’ needs are being met. Discussions with family confirmed values and beliefs are considered. Residents are provided with church services of their choice. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Job descriptions include responsibilities of the position and signed copies of all employment documents were included in the five staff files reviewed. Staff comply with confidentiality and the code of conduct. Staff meetings include discussions on professional boundaries and concerns/complaints as they arise (minutes sighted). Interviews with the manager, RN and care staff confirmed an awareness of professional boundaries. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The service has policies to guide practice that align with the health and disability services standards. Staffing policies cover pre-employment processes and the new employee’s requirement to attend orientation and ongoing in-service training. The manager is responsible for coordinating the internal audit programme. Quarterly staff meetings are conducted. There is a regular in-service education and training programme for staff. Staff interviewed stated that they feel supported by the manager and two RNs.  Evidence-based practice is evident, promoting and encouraging good practice. The roster indicates the on-call RN when an RN is not on-site. A house general practitioner (GP) visits the facility once per week. The service receives support from the local district health board (DHB). Physiotherapy services are available as required. A podiatrist visits every six to eight weeks.  Quality initiatives since the previous audit have included adding a clinical room for the GP, the transition of the medication management system to an electronic system, purchase of a laptop and new tablet, construction of a paved pathway outdoors (link to CI 1.3.7.1), and the development and implementation of resident information forms to assist the GP and caregivers.  Families interviewed spoke positively about the care and support provided. This was also evidenced in the recent satisfaction survey results (November 2017). |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | There is a policy to guide staff on the process around open disclosure. Fifteen incident forms reviewed for June and July 2018 identified that family were notified following a resident incident/accident, except under circumstances that indicated otherwise. The manager and RN confirmed family are kept informed. The families interviewed also confirmed they are notified promptly of any incident/accident.  In addition to handover, a communications book is utilised to assist in sharing information with staff between shifts. Family members advised that they are encouraged to discuss any concerns with the manager and/or registered nurse. Non-subsidised residents’ family are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. Family are also informed prior to entry of the scope of services and any items they have to pay for that is not covered by the agreement. The service has access to an interpreter service. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Bradford Manor provides care for up to 26 rest home dementia level of care residents with 23 residents living at the facility on the day of audit. There were no respite residents. The service is part of the Elsdon Enterprises Group who provides governance and management support to the manager.  The manager (non-clinical) is responsible for the day-to-day running of the home. She has been in her role for the past 12 years. Clinical oversight is provided by an experienced clinical lead/registered nurse.  Bradford Manor has a quality assurance and risk management programme in place. There is a business plan for 2017 – 2018 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.  The manager has maintained at least eight hours annually of professional development activities related to managing a rest home. Year to date she has attended external training courses around human resources and dementia care. |
| 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 clinical lead/RN has been in the role for eight years and provides cover for the manager in her absence. A staff RN provides cover in the absence of the clinical lead. |
| 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 | The business, quality and risk management plan is reviewed annually to measure achievements. The service has implemented a range of policies and procedures to support service delivery. A system of document control is in place. All policies have been reviewed in 2018.  Key components of service delivery are linked to the quality and risk management system including resident satisfaction, internal audits, health and safety, the management of adverse events, restraint minimisation and infection prevention and control. Data is evaluated, and results are used for quality improvement.  The quarterly staff meetings include feedback to staff around quality and risk data. Information is also shared with staff daily during handovers. Interviews with staff confirmed that they are kept informed in relation to quality and risk activities. Corrective actions are documented and implemented. Quality initiatives are also documented.  Actual and potential risks are identified, documented and where appropriate communicated to residents, their family/whānau of choice, visitors, and staff. The service maintains a hazard register. Hazards are identified, controlled, monitored, and reviewed. |
| 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 | A sample of 15 accident/incident forms for June and July 2018 were reviewed. There has been RN notification and clinical assessment completed in a timely manner. Accidents/incidents were recorded in the resident progress notes. There is documented evidence the family/whānau had been notified promptly of accidents/incidents.  The service collects incident and accident data and reports aggregated figures in the staff meetings. Staff interviewed confirmed incident and accident data are discussed and information and graphs are made available.  Discussions with the manager confirmed her awareness of the requirement to notify relevant authorities in relation to essential notifications. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | There are human resource management policies in place that include the recruitment and staff selection process. Relevant checks are completed to validate the individual’s qualifications, experience and veracity. Copies of current practising certificates are retained. Five staff files (one RN, four caregivers) reviewed, evidenced implementation of the recruitment process, employment contracts, completed orientation and annual performance appraisals.  The orientation programme covers three areas; general orientation, health and safety and a separate competency assessment around caring for residents with dementia. Staff interviewed were able to describe the orientation process and reported new staff were adequately orientated to the service. The in-service education programme for 2017 has been completed and the education plan for 2018 is being implemented. In-services are conducted monthly (at a minimum). The clinical lead/RN has been trained in interRAI.  Eleven caregiver staff are currently employed in the dementia unit. Ten of the eleven staff have completed the required NZQA dementia standard. One caregiver, who has been employed for less than one year, is currently working on completing her qualification. All care staff have received recent in-service training around challenging behaviours and caring for residents with dementia with the most recent in-service on 16 May 2018. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | A staffing protocol is in place. Sufficient staff are rostered to manage the care requirements of the residents. There are two RNs employed by the service (including the clinical lead) with on-site cover provided Monday – Friday. The clinical lead works from 9.00 am – 5.00 pm four days a week and the staff RN covers from 1.00 pm – 5.00 pm five days a week. The clinical lead reported that her hours can fluctuate across all three shifts, especially when completing interRAI assessments, in order to get a more complete picture of the resident.  The clinical lead is on-call when not available on-site with support provided by the staff RN who is rostered on call for two days a week.  Twenty-three residents were living in the dementia unit. A minimum of two caregivers are rostered on the afternoon and night shifts with three caregivers rostered on the AM shift (two long shift, and one short shift). A carer responsible for medication administration works from 8.00 am – 10.30 am Monday through Friday. Two additional hours are rostered for weekend medication rounds, covered by caregiver staff.  Caregivers also provide laundry services. Maintenance staff are also responsible for cleaning. The diversional therapist is employed five days a week (30.5 hours).  Staff reported that staffing levels and the skill mix were appropriate and safe. Families interviewed advised that they felt there was sufficient staffing. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The resident files are appropriate to the service type. All relevant initial information is recorded within required timeframes into the resident’s individual record. Resident records containing personal information is kept confidential. Individual resident files demonstrate service integration.  Entries were legible, dated and signed by the relevant caregiver or registered nurse including designation. |
| 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 | Residents are assessed prior to entry to the service by the needs assessment team, and an initial assessment was completed on admission in files sampled. The service has an information pack available for residents/families/whānau at entry and it includes associated information such as the Code, advocacy, informed consent, and the complaints procedure. All of the six files reviewed included the admission agreement, which aligns with the ARC contract and exclusions from the service are included in the admission agreement. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | The transfer/discharge/exit procedures included a transfer/discharge form, with the completed form placed on file. The service stated that a staff member escorts the resident if no family were available to assist with transfer, or ensure relatives meet the resident at the hospital. Copies of documentation are forwarded with the resident. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | The service has implemented an electronic medication system. Medications are managed appropriately, in line with required guidelines and legislation. Ten medication charts were reviewed. All regular medications are robotic packed in four weekly cycles. ‘As required’ medications are blister packed. The medication trolley is locked in the treatment room with keypad access. There are no expired medications, eye drops, and creams are dated on opening. Medication charts sampled were reviewed three monthly by the attending GP. Resident photos and documented allergies or nil known were evident on all 10 medication charts reviewed. An annual medication administration competency was completed for all staff administrating medications and medication training has been conducted.  The service has a policy and procedure around resident self-medicating. It is actively discouraged due to the cohort of residents. Residents and family are advised of this on admission and is included in the pre-admission information pack. There were no residents self-medicating at Bradford Manor. |
| 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 | A food control plan expires on 31 August 2019. All meals and home baking are prepared and cooked on-site. There is a four-weekly seasonal menu in place which had been reviewed by a dietitian. The chef is informed of resident dietary needs and changes. Likes and dislikes are accommodated. Additional or modified foods such as soft foods, pureed and vegetarian meals are able to be provided. Cultural needs are accommodated. Relatives interviewed were very complimentary about the meals provided.  Meals are well presented and freshly cooked, and residents who required assistance had support from the staff. Nutritional supplements are available. Finger foods are available for residents 24/7. Fridge and freezer temperatures are monitored and recorded daily. End cooked temperatures are recorded. All containers of food stored in the pantry are labelled and dated. All perishable goods are date labelled. A cleaning schedule is maintained. Staff have been trained in food safety. |
| 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 reason for declining service entry of residents to the service would be recorded on the declined entry form, and when this has occurred, the service stated it had communicated to the resident/family/whānau and the appropriate referrer. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | All residents were admitted with a care needs level assessment completed by the needs assessment and service coordination team prior to admission, in files sampled. Personal needs information is gathered from family during admission, which formed the basis of resident goals and objectives in files sampled. Risk assessments including (but not limited to), falls, pressure area, continence, pain and nutrition were completed on admission and reviewed at least six-monthly. Assessments such as behavioural assessments were completed for identified behavioural issues in files sampled. The registered nurse/clinical lead interviewed has completed interRAI training and the assessment tool was evident in resident files sampled. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | The integrated care plans are paper-based. The long-term care plan records the resident’s problem/need, interRAI triggers, objectives, interventions and evaluation for identified issues. The initial care plan is developed from the initial assessment and identifies the areas of concern or risk. The long-term care plans reviewed included the resident’s current abilities, their level of independence, the problem/need, objectives and interventions for identified issues. Short-term care plans are utilised for acute health needs such as infections. Specific individualised behavioural management strategies were included in care planning. Resident files reviewed, and family interviews identified that family were involved in the care plan development and ongoing care needs of the residents. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Care plans reviewed were current with interventions updated. Communication with family is documented on the family/whānau consultation sheet or in progress notes.  Continence products are available and resident files include a urinary continence assessment. Specialist continence advice is available as needed and this could be described by the clinical lead.  Monthly weighs have been completed in all six files sampled. Referral to dietitian occurs as required, as confirmed by registered nurse interview.  Dressing supplies are available, and the treatment room is stocked for use. There were no residents with pressure injuries on the day of the audit. There were two residents with wounds on the day of the audit, both had a documented assessment and plan and have been evaluated in a timely manner.  Short-term care plans are available for use for changes in health status. |
| 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. | CI | The files reviewed identified that the individual activity plan is developed based on a resident social profile and activity assessment. The activities plan has resident-focused goals with a monthly progress report, six monthly evaluations and attendance record for individual residents. There is an extra “individual activity to support daily living” page in the care plan to assist staff in providing activities that are meaningful to each individual resident over a 24-hour period. The programme of activities is provided five days a week by the diversional therapist, and involves maintaining the resident’s interests along with community involvement when possible. The staff have access to the activities cupboard in the evenings and weekends to provide activities for residents. There is a variety of group activities such as card games in the dining room area, for residents who do not like to move much during the days, there are games with balloons or floor games set up in the lounge area to encourage these residents to participate if they wish.  Some residents enjoy painting, they collect small items of furniture from the salvation army to take back to the facility, the residents’ sand and paint the items, some residents enjoy stencilling, so some pieces are decorated with stencils. There are painted canvasses for residents to decorate for their rooms. Residents can be supervised by staff during these activities while the diversional therapist spends one-on-one time with other residents.  An iPad has been purchased to record special moments of residents participating in activities, and these are sent to relatives, as some relatives do not live locally and are not able to visit regularly. This is a way of keeping relatives in touch. The diversional therapist noticed the residents particularly like music, so purchased a keyboard, which residents enjoy, and can take this to a quieter space if other residents don’t like it. There are three guitar players and a resident who likes playing the electronic drums. The diversional therapist showed videos to convey the delight and pleasure the residents feel when playing musical instruments. There is a video of a resident singing along to the entertainment and another resident dancing to the music. The diversional therapist reports residents who did not previously engage in many activities are now participating in the musical activities.  Bradford Manor has a van for outings. The activities plan is posted on the hallway noticeboard. Family interviews indicated they find the programme enjoyable and interesting. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Comprehensive evaluations reviewed were completed six-monthly by the registered nurse or clinical lead of all goals and objectives identifying the degree of achievement and were updated as changes were noted in care requirements. Short-term care plans were in use and are evaluated regularly, or added to long-term care plans.  The GP reviews residents three monthly or when requested if issues arise or health status changes. The relatives interviewed confirmed they are invited to attend resident reviews, and feel they are well informed of changes. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | The service facilitates access to other medical and non-medical service, (eg, diabetic services, physiotherapist, wound care specialist and mental health services for older people). Referrals to specialists are made by the GP or by the clinical lead following discussion with the GP. Referral forms and documentation are maintained on resident files as sighted. Relatives interviewed reported they are involved as appropriate when referral to another service happens. |
| 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 designated areas for storage of cleaning/laundry chemicals and chemicals were stored. Chemicals are labelled with manufacturer labels, and all chemicals used are in original containers. Safety data charts were available for all chemicals in use. Laundry and sluice rooms are locked when not in use. Gloves, aprons, and face visors are available for staff. Safe chemical handling training has been provided. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | Bradford Manor displays a current building warrant of fitness, which expires on 20 December 2018. Hot water temperatures are checked monthly with temperatures recorded noted to be within acceptable limits. Medical equipment has been calibrated. Test and tagging of electrical appliances is completed on an annual basis. Regular and reactive maintenance occurs. Residents were observed to mobilise safely within the facility. There are sufficient seating areas throughout the facility. The exterior is secure and has been well maintained with ramps, safe paving, outdoor shaded seating, lawn and gardens. Caregivers interviewed confirmed there was adequate equipment to carry out the cares according to the resident needs as identified in the care plans.  The service has a van for transporting residents, which has a current registration and warrant of fitness.  An activities room previously used for storage has been converted into a resident bedroom. The room is of adequate size with external window, and fan heater and the staff can regulate the temperature. Call bell is within reach of the resident. (Note: One resident room was converted to a clinical room so there has been no overall change in the number of certified beds). |
| 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 resident communal toilets in close proximity to resident rooms and communal areas. Visitor toilet facilities are available. The communal toilets are well signed and identifiable and include vacant/in-use signs. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | All resident rooms at Bradford Manor are single rooms and personalised to resident taste. The resident rooms are of sufficient size to meet the resident’s assessed needs. Residents are able to manoeuvre mobility aids around the bed and personal space. All beds are of an appropriate height for the residents. Caregivers interviewed reported that rooms have sufficient space to allow cares to take place. |
| 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 | Bradford Manor has resident rooms in two corridors. There is a large lounge and dining area and a small lounge on the other side of the building where the new path leads. All areas are easily accessible for the residents. The communal areas are accessible to the outdoor areas. Activities take place in either of the communal 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 | Bradford Manor has documented systems for monitoring the effectiveness and compliance with the service policies and procedures. There is a separate laundry area with separate clean and dirty areas where all linen and personal clothing is laundered by the care staff. Staff attends infection control education and there is appropriate protective clothing available. Manufacturer’s data safety charts are available. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | Bradford Manor has a New Zealand Fire Service approved fire evacuation plan in place. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Emergency equipment is available at the facility. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and gas cooking. Short-term backup power for emergency lighting is in place.  Visitors and contractors sign in at reception when visiting. Fire drills have been conducted six-monthly. There is a staff member with a first aid certificate on each shift. There are call bells in the residents’ rooms, and lounge/dining room areas. Residents’ rooms were observed to have their call bells in close proximity. |
| 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 | All communal areas and resident bedrooms have external windows with plenty of natural sunlight. General living areas and resident rooms are appropriately heated and ventilated. Relatives interviewed stated the environment was warm and comfortable. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | The clinical lead/RN is the infection control coordinator. The infection control coordinator has a job description. Infection control committee includes all staff and discussion is included in staff meetings. The infection control programme has been reviewed in January 2018. Visitors are asked not to visit if they have been unwell. There are hand sanitisers throughout the facility and adequate supplies of personal protective equipment. Residents and staff are offered influenza vaccines. There have been no outbreaks since the last audit. |
| 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 | Infection control is managed by the infection control coordinator. The infection control coordinator has attended external education. The infection control committee includes all staff. The infection control coordinator has access to infection control personnel within the district health board, public health, laboratory services and GP service. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available. |
| 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 | The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes the infection control programme, responsibilities and oversight, training and education of staff. The policies have been reviewed and updated annually and reflect relevant legislation and accepted good practice. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The infection control coordinator is responsible for coordinating/providing education and training to staff. Infection control education is provided annually and includes wound care, hand hygiene and food safety. Staff interviewed confirmed informal education around relevant infections control matters at handover. |
| 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 | There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place, appropriate to the complexity of service provided.  Systems in place are appropriate to the size and complexity of the facility. The infection control coordinator collects the infection rates each month. The data is analysed to identify trends and determine infection control quality initiatives and education within the facility. Infection control data is communicated to staff and management through meetings. Care staff interviewed were knowledgeable about infection control practices. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. The policy includes restraint procedures. The policy identifies that restraint is used as a last resort. There were no enablers or restraints in use. The clinical lead/RN is the restraint coordinator. Training in restraint and challenging behaviour has been provided. |

# Specific results for criterion where corrective actions are required

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

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

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

|  |
| --- |
| No data to display |

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

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

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

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

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| Criterion 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. | CI | Bradford Manor plan activities around the resident’s interests and current ability. The diversional therapist is dedicated to providing an activities programme that suits the needs of residents as conditions change. The programme is designed to offer residents the opportunity to try something new, or maintain or improve current level of activity. | A new tar sealed pathway has been developed around the building from the front gate around the property to the rear door leading into the small lounge to encourage residents to become more active. Residents previously used a path, which was slippery in the winter. The new tar sealed path allows residents to walk in a loop around the building through all seasons. Staff reported the residents were very interested in the development of the path, which they report has encouraged the residents to go out for walks.  There is a walking group, where a group of residents, the diversional therapist and a volunteer go to the botanical gardens for a walk each week. The path is used to gauge the fitness of the residents as they need to be able to walk around the “loop” three times (measured distance between the benches at the gardens) to be able to join the walking group. Some residents have decided to improve their fitness so that they can join the walking group. Since the new sealed path has been completed there are four residents who previously did not go for walks now out walking. |

End of the report.