# Elsdon Enterprises Limited - Bradford Manor

## Introduction

This report records the results of a Surveillance 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: 29 July 2020 End date: 30 July 2020

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

**Total beds occupied across all premises included in the audit on the first day of the audit:** 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 is part of the Elsdon Enterprises Group. The service is certified to provide dementia level of care for up to 26 residents. On the day of audit there were 23 residents.

This unannounced surveillance 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.

A non-clinical manager is responsible for the day-to-day running of the home, with clinical oversight provided by an experienced clinical lead/registered nurse. Bradford Manor has a quality assurance and risk management programme in place. The activities programme is varied and designed to meet the needs of residents.

Relatives and the general practitioner interviewed commented positively on the standard of care and dedication of staff at Bradford Manor Rest Home.

This audit identified an improvement around medication documentation.

The service has exceeded the standard around infection control and the management of COVID 19.

## Consumer rights

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| 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. |

There is a policy to guide staff around open disclosure. Relatives are advised of incidents and accidents and this is recorded in progress notes and in the family contact sheet.

The manager leads the investigation of any concerns/complaints and the complaint’s register is up to date.

## Organisational management

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| 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 has a quality assurance and risk management programme. The quality plan is being implemented. Data is evaluated and results used for quality improvement. The service maintains a risk register and a hazard register.

There are human resources policies to support, recruitment practices and staff appraisals are up to date. The education planner covers compulsory education requirements as well as additional subjects.

There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. There is a minimum of two caregivers on duty at any one time.

## Continuum of service delivery

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| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

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.

A medication management system is implemented and all staff have completed annual competencies for medication administration. There are three-monthly GP medication reviews.

All food is prepared 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. Nutritious snacks are available 24/7.

## Safe and appropriate environment

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

The building has a current warrant of fitness. Preventative and reactive maintenance occurs. Hot water temperature is checked and within safe limits. The building is spacious and provides safe access to all areas for residents using mobility aids.

## Restraint minimisation and safe practice

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

The service has policies and procedures to appropriately guide staff around the use of enablers or restraints. The registered nurse is the restraint coordinator. There are no residents using enablers or restraints.

## Infection prevention and control

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

The clinical lead/RN is the infection control coordinator. Surveillance data is collated, analysed for trends and discussed at meetings. Bradford Manor continue to implement COVID 19 precautions around the monitoring of visitors prior to entry to the facility.

## Summary of attainment

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

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **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 | 15 | 0 | 0 | 1 | 0 | 0 |
| **Criteria** | 1 | 42 | 0 | 0 | 1 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

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

|  |  |  |
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| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | Complaints forms are available at the entrance to the facility. Information around the complaints process is provided on admission. A record of all complaints, both verbal and written is maintained by the facility manager on the complaints register. A Health and Disability Commission (HDC) complaint was filed in 2019. The Health and Disability commissioner concluded that no further action was required. However, the Ministry has requested follow-up against aspects of the complaint including adverse event reporting, appropriately skilled staff and equipment availability, service provision and assessed needs, clinical care and liaison with specialist services. There were no issues in respect of this complaint identified during this audit. Following the HDC complaint a debrief meeting was held for staff facilitated by the Hospice and counselling was offered to staff affected. One verbal complaint was received in 2019, this was resolved at the time of the complaint to the complainant’s satisfaction.  Staff interviewed (one clinical lead/RN, four caregivers, one registered nurse, one cook, one maintenance person, one cleaner and the diversional therapist) confirmed that complaints and any required follow-up is discussed at staff meetings as sighted in the minutes, and described directing anyone with issues or concerns to the most senior person on duty. Relatives advised that they are aware of the complaints procedure and how to access forms. The relatives interviewed felt comfortable discussing issues and concerns with the manager and clinical lead. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Comprehensive information is provided at entry to residents and relatives/whānau. Five relatives interviewed stated that they and their loved one were welcomed on entry and were given time and explanation about the services and procedures. Both the manager and clinical lead/RN was available to residents and relatives and they promote an open-door policy. Incident forms reviewed in June and July 2020 evidenced that relatives had been notified on all occasions. Relatives interviewed advised that they are notified of incidents and when residents’ health status changes promptly. During the COVID 19 lockdown relatives reported they were well informed and updated of residents’ wellbeing, and new policies/procedures as appropriate.  Interpreter services are available when required. |
| 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 including two residents on a long-term support - chronic health contract (LTS-CHC). All other residents were on the Aged Related Residential Contract (ARRC). The service is part of the Elsdon Enterprises Group who provides governance and management support to the manager.  There is an annual business plan 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. A quality assurance and risk management programme is in place with goals including the implementation of an electronic timesheet system, continued refurbishments, and ongoing input to the music therapy programme. An annual review of the quality programme is conducted by the manager. Quality initiatives that have been implemented since the previous audit include the use of dressing gowns for night staff to help orientate residents to night-time, the use of music therapy and the COVID response.  The manager (non-clinical) is responsible for the day-to-day running of the home. She has been in her role for the past 16 years. Clinical oversight is provided by an experienced clinical lead/registered nurse who has been in her role for 13 years. They are supported by a part time registered nurse and long standing experienced and dedicated staff. |
| 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 | Bradford Manor is implementing a quality and risk management system. An internal audit programme is in place that includes aspects of clinical care, and corrective actions arising from internal audits are resolved at the time. The closure of corrective actions resulting from internal audit programme was recorded, signed off by the manager who makes comment around discussions in meetings, education requirements and observations. Three monthly managers’ meetings are held prior to the three monthly combined quality/staff meeting, where any feedback from the managers meeting is discussed. Meeting minutes include an accurate reflection of the discussion/outcomes of the meetings, including follow-up to actions taken as matters arising.  Monthly accident/incident reports, and infection reports are documented. Quality matters are taken to the combined staff/quality meetings which includes health and safety and infection control. While there are no formal resident or relative meetings the relatives interviewed felt they can give feedback through the surveys and stated the manager and clinical lead have an open-door policy and are always available. The relatives are also kept up to date through the emails sent by the diversional therapist.  A relative survey has been completed annually; the 2020 survey has not yet been sent. The 2019 survey had a poor response, with the relatives who did respond having no concerns and were very satisfied with all aspects of the service. The relatives interviewed stated the management team are so available, any questions or feedback is provided in a more informal way. One relative commented the resident didn’t like breakfast, the request for eggs on toast was accommodated  Health and safety was discussed at the combined meetings, the manager is the health and safety officer with the company’s operations manager overseeing health and safety issues and concerns. A monthly report is provided to the operations manager. The hazard register was last reviewed in 2019. Bradford Manor has an unofficial focus on staff wellness including pizza teas, and regular morning teas provided for staff. Falls prevention strategies are individualised and in place for all residents.  Bradford Manor continue to gain feedback and ‘Thank-you’ cards and emails from relatives around the management of COVID 19. |
| 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 | Bradford Manor collects incident and accident data and reports aggregated figures monthly to the quality meeting. Incident forms are completed by staff, the resident is reviewed by the RN at the time of event and the form is forwarded to the clinical lead for final sign off. Ten incident forms reviewed identified registered nurse follow-up. Incident/accident forms include a section to record relatives have been notified. Neurological observations were completed for all unwitnessed falls and a registered nurse documented opportunities to minimise future risk. Minutes of the combined quality/staff meetings reflected a discussion of incident statistics; analysis and a three month look back analysis of any corrective actions. The caregivers interviewed could discuss the incident reporting process, and procedures when a registered nurse is not on site.  During the lockdown period while staff were staying on site 24/7 it was noted that incident numbers dropped to two incidents in March and one incident in April.  Discussions with both the manager and clinical lead confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. The manager reported there has been one section 31 notification (not sighted) made since the last audit, the manager and clinical manager described the process of documentation including incident reporting and informing the relatives during and following the incident. This resident was referred for further assessment. |
| 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 resources policies to support recruitment practices. A list of practising certificates is maintained. Five staff files were reviewed (three caregivers, one cook and one registered nurse). All had relevant documentation relating to employment and current appraisals.  The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme includes documented competencies and induction checklists (sighted in files). Staff interviewed were able to describe the orientation process and believed new staff were adequately orientated to the service.  There is an education plan that is being implemented that covers all contractual education topics and exceeds eight hours annually. A competency programme is in place that includes annual medication competency for staff administering medications. Core competencies are completed, and a record of completion is maintained and signed. Competency questionnaires were sighted in reviewed files. All staff have completed the dementia standards. Education sessions on challenging behaviour management, dementia and medications have been held.  The clinical lead and the registered nurse are interRAI trained. There is evidence in the clinical lead education file of attendance at the District Health Board (DHB) external training. The clinical lead is the link nurse for Hospice and has attended training.  Nine caregivers and the diversional therapist have obtained New Zealand Qualifications Authority (NZQA) qualifications and all staff are first aid trained. Four caregivers have enrolled in a palliative care course (external) provided by the Hospice.  The manager has enrolled in an open university course on ‘Managing and managing people’ and attends ARRC meetings. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | Bradford Manor has a documented rationale for determining staffing levels and skill mixes for safe service delivery.  There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. The non-clinical manager works five days a week (Monday to Friday) and is supported by the clinical lead Monday and Wednesday) and a registered nurse who works Tuesday, Thursday and Friday.  They are supported by three caregivers in the morning; 2x 7 am to 3.30 pm, 1 x 7 am to 11 am this shift can be extended when acuity of residents is higher.  Two caregivers work in the afternoon shift; 2 x 3.30 pm to 11 pm and two caregivers work night shift from 11 pm to 7 am.  The manager is on call for non-clinical matters and the registered nurses are on call for all clinical matters.  Interviews with the registered nurse, caregivers and relatives confirmed that there are sufficient staff to meet care needs. If additional (specialised) equipment is required, this can be accessed quickly from sister facilities in Dunedin. A syringe driver is available for residents. The registered nurses are competent in the use of syringe drivers. A registered nurse is available to remain on site or within close vicinity if a syringe driver is required. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate | The service has implemented an electronic medication system. Medications are managed appropriately. 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 medication room with keypad access. Controlled drugs are appropriately stored, however not all checks were consistently completed. There were 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 the ten medication electronic charts reviewed. An annual medication administration competency was completed for all staff administrating medications and medication training has been conducted. There were no residents self-medicating at Bradford Manor. The clinical lead has a syringe driver competency and the registered nurse will complete this when next available. |
| 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 has been verified expiring in February 2021.  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 cook 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 can be provided. Cultural needs are accommodated. All containers of dry food stored in the pantry are labelled and dated. All perishable goods are date labelled. Fridge and freezer temperatures are monitored and recorded daily. End cooked temperatures are recorded using the food control plan handbook.  A cleaning schedule is maintained. Staff have been trained in food safety and have been enrolled onto a refresher course.  Meals are well presented and freshly cooked, and residents who required assistance had support from the staff. Nutritional supplements are available. Nutritional snacks are available 24/7. The cook interviewed was aware of residents’ food preferences and residents with unintentional weight loss. Relatives interviewed were very complimentary about the meals provided. Residents were observed in the dining room, staff providing residents with assistance did so in a dignified manner. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | When a resident's condition alters, a registered nurse initiates a review and if required, GP, nurse specialist consultation. Changes in condition are discussed with the relatives. When a significant deterioration in condition occurs, the registered nurse discusses the option to move the resident to hospital or hospice with the relative/ Enduring Power of Attorney (EPOA) if they would prefer.  The registered nurses and caregivers follow the plan and report progress against the plan each shift. There is documented evidence on the family contact form in each resident file that indicates relatives were notified of any changes to their relative’s health. Discussions with relatives confirmed they are notified promptly of any changes to their relative’s health. Short-term care plans are used for short-term/acute changes in care. These were in place for wounds and infections in the resident files reviewed. There were three superficial wounds on the day of the audit including two skin tears and a biopsy wound. All wounds had individual wound assessments, plans and evaluations which indicated progression or deterioration of the wounds. Adequate dressing supplies were sighted in the treatment room.  Residents with challenging behaviours had monitoring forms maintained, triggers, behaviours, and de-escalation techniques specific to this resident were in place. Pain assessments and monitoring charts were utilised for a resident with acute pain. Allied health input was in place from Hospice and mental health for older people for two of the residents’ files reviewed.  Monitoring forms sighted and maintained included (but not limited to) weight, vital signs, food and fluid, behaviour, and blood sugar monitoring.  Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified. There is access to a continence nurse specialist by referral. Residents are weighed monthly or more frequently if weight is of concern. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The diversional therapist (DT) provides activities over five days a week, with a mixture of three whole days and two afternoons. An individual activity plan is developed for each resident based on the 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. Bradford Manor has a van for outings. The activities plan is posted on the hallway noticeboard beside the photo board of residents participating in activities. Relatives interviewed like this board, as they can see what has been going on.  The programme includes church services fortnightly, with all denominations participating, weekly communion is available for residents. Staff and relatives reported it was not unusual to see at least two activities occurring at any one time, with a group of residents painting, another playing a table game and others playing music. The walking group has not been able to go walking due to restrictions with COVID, however the path is still utilised by residents as witnessed during the audit.  The residents at Bradford Manor continue to paint furniture for the Salvation Army, the DT continues to keep relatives updated with what their loved one has been busy doing, by sending emails and videos of their resident attending activities. Music therapy has become a highlight for residents, with residents continuing to play the guitars, and musical instruments such as electric drums, and a keyboard which have been donated or bought to increase the variety of instruments available. Headsets have been purchased so residents can enjoy music therapy, this has had an ongoing calming effect and caregivers reported that residents are more relaxed. There is a large proportion of residents participate who in either the music therapy or the music sessions. During the audit, residents were colouring, playing table games, and participating in exercises. One-on-one sessions are held later in the day and include nail care, small group sessions playing cards, colouring, and calmer activities. The staff have access to the activities’ cupboard in the evenings and weekends to provide activities for residents. Relative interviews indicated they find the programme enjoyable and interesting with plenty of activities to choose from. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | All initial care plans for long-term residents were evaluated by the clinical manager or registered nurse within three weeks of admission and long-term care plans developed. Long-term care plans have been evaluated by the clinical manager or registered nurse six monthly, using the interRAI tool or earlier for any health changes for files reviewed. The GP reviews the residents at least three-monthly or earlier if required. Ongoing nursing evaluations occur as indicated and are documented within the progress notes or the care plan. The short-term care plans have been reviewed and evaluated |
| 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 2020. Regular and reactive maintenance occurs. Medical equipment has been calibrated. Testing and tagging of electrical appliances is completed on an annual basis. Hot water temperatures are checked monthly with temperatures recorded noted to be within acceptable limits. Residents were observed to mobilise safely around the facility. There are sufficient seating areas throughout the facility. The exterior is secure all around the building with a small mesh fence to the rear of the building and a wooden fence at the front. External areas are well maintained with ramps, lawn and gardens which provide seating and shade. Caregivers interviewed confirmed there was adequate equipment to carry out the cares according to the resident needs as identified in the care plans. Cleaning schedules were reviewed during COVID 19 and these continue to be implemented. The service has a van for transporting residents, which has a current registration and warrant of fitness. |
| 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. | CI | The clinical lead/RN is the infection control coordinator. The infection control coordinator has a job description. The 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.  The service exceeded the standard in the management of the recent COVID 19 pandemic. |
| 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 | Bradford Manor continue to implement their infection surveillance programme. Individual infection alert forms were completed for all infections. Infections were included on a monthly register and a monthly report and graphs were completed by the infection control coordinator (clinical lead/RN). Infection control issues were discussed at the combined quality and staff meetings. The infection control programme is linked with the quality programme. In-service education is provided annually and in toolbox talks when required. There have been no outbreaks since the previous audit. |
| 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 in February 2020. |

# Specific results for criterion where corrective actions are required

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

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

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.3.12.6  Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines. | PA Moderate | An electronic medication system is in place with medications, dose and indications for use correctly documented. A controlled drug register is in place, with entries entered correctly as per policy by two medication competent staff. The register is checked by the pharmacist on a six-monthly basis, however the weekly check by staff has not been completed consistently on a weekly basis. | Weekly checks of the controlled drug register have not always been completed, with gaps of up to four weeks. | Ensure the controlled drug checks are completed on a weekly basis.  90 days |

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

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

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

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

|  |  |  |  |
| --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| Criterion 3.1.3  The organisation has a clearly defined and documented infection control programme that is reviewed at least annually. | CI | A staff meeting was held to discuss the impending coronavirus and the potential implications for the residents and staff. Staff were asked for their input and thoughts of how to best manage the pandemic and lockdown. | COVID 19 policies and procedures, care plan templates and all documentation received including information from the Ministry of Health (MOH) was discussed with staff as new information arrived at handovers and maintained in resource folders. Records of temperature checks of staff and residents were maintained, contact screening of staff and members of family in each member of staffs’ bubble’ was documented. Nine of the caregiving staff offered to ‘move into’ the facility in a bid to provide better protection from COVID 19 entering the facility, therefore reducing the risk to the residents.  A changing room was set up in the car port so staff could change clothes prior to entering the facility. Separate baskets were provided for individual staff clothes and a shoe rack for shoes. Each member of staff not residing at Bradford Manor followed strict protocols regarding showering and laundering of clothes at home. The oncoming staff alerted staff to open the gate and were screened prior to entering the building. Hand sanitiser was available in the changing area, and prior to entering the facility. All deliveries were left at the gate for staff to collect. Once visitors could visit, strict protocols and registers were maintained. Wellness registers remain in place and were completed by each visitor entering the facility.  A debrief meeting was held once in level 3, observations included a reduction of falls and incidents, the reduced impact of isolation and lack of visitors to residents because of staff staying maintaining consistency. There were no follow-up recommendations following the COVID preparedness audit by the DHB.  The manager reported they have received gifts of honey, a hamper, CDs and gifts for the residents and staff from local businesses. The staff have participated in the Otago university research programme. Staff have commented on the feeling of camaraderie and have a greater respect for the workloads and stresses staff feel on each shift. The caregivers interviewed stated this was a special time to spend with the residents as they really got to know their personalities and preferences, which has been reflected in the care plans to enhance the care provided. Relatives were free to phone or use video calls to keep in touch with residents. Relatives interviewed were incredibly happy and complimentary of the dedication and high standard of care provided to the residents especially during the COVID period. |

End of the report.