

Birchleigh Management Limited

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](#).

The specifics of this audit included:

Legal entity:	Birchleigh Management Limited
Premises audited:	Birchleigh Residential Care Centre
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 1 December 2014 End date: 1 December 2014
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:	81

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

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

General overview of the audit

Birchleigh residential care centre provides rest home, dementia and hospital level care to up to 81 residents with full occupancy on the day of the surveillance audit. The facility is managed by the chief executive officer (CEO) of Chatsford Management Ltd which comprises the Birchleigh residential care centre and the adjacent Chatsford retirement village. The service is governed by a board of directors who receive monthly reports from the CEO.

The care centre has three units - a 24 bed hospital, a 24 bed dementia unit, and a 33 bed rest home unit. Each unit is managed by a registered nurse manager with support from care staff, ancillary and administration staff.

The service has addressed five of five previous shortfalls relating to recording of incidents in progress notes, completion of annual appraisals for nurse managers, conducting comprehensive medication competencies for registered nurses, including information around the dementia unit in the information pack, and timeframes for completion of care plans.

There is one improvement required around wound assessment documentation.

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.
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The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Communication with residents and families is conducted and recorded. Complaints and concerns have been actively managed and documented. A complaints register is maintained.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Birchleigh residential care centre is governed by a board of directors with management provided by a chief executive officer and three unit nurse managers. The nurse managers are supported by registered nurses and care staff. The CEO, nurse managers and another non-clinical manager are responsible for the implementation of the quality and risk management programme. The quality and risk management programme includes service philosophy, goals and a quality planner. Quality activities are conducted and this generates improvements in practice and service delivery. Key components of the quality management system link to monthly quality meetings with three monthly unit staff meetings. Corrective actions are implemented, documented and followed through to resolution. Residents and families are surveyed six weeks post admission and through resident meetings. Health and safety policies, systems and processes are implemented to manage risk. Discussions with families identified that they are fully informed of changes in health status. There is a comprehensive orientation programme that provides new staff with relevant information for safe work practice and an in-service education programme that exceeds eight hours annually and covers relevant

aspects of care and support. Human resource policies are in place including a documented rationale for determining staffing levels and skill mixes. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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An information pack for prospective residents includes specific details on the dementia unit activities programme, restraint minimisation and management of challenging behaviours. The service has addressed this previous finding. Residents have a need assessment completed prior to entry to the service. Residents' assessment, care planning and care evaluations are developed by the registered nurses in partnership with the resident and/or their family, as appropriate. A review of all residents' clinical files validates the service delivery to the residents. Residents and family interviewed confirm satisfaction with the care delivery provided at the facility. Sampling of residents' clinical files validates the service delivery to residents. Evaluations of care plans are within stated timeframes and reviewed more frequently if a resident's condition changes and this is noted on a short term care plan.

Planned activities are appropriate to the group setting. Residents and family interviewed confirm satisfaction with the activities programme. An appropriate medicine management system is in place. Policies and procedures record service provider responsibilities. Staff responsible for medicine management had completed medication competencies, and attended in-service education on medication management. A central kitchen and on site staff provide the food service for the three units. Kitchen staff had completed food safety training. Residents' individual needs are identified, documented and reviewed on a regular basis. The menu has been reviewed by a dietitian. There was positive feedback from residents about the food service.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The building has a current building warrant of fitness which expires on 3 March 2015.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Documentation of policies and procedures and staff training demonstrate residents were experiencing services that were the least restrictive. There were 10 hospital residents with enablers and two hospital residents with restraint.

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.
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The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	16	0	1	0	0	0
Criteria	0	39	0	1	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](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The service has a complaints policy in place and residents and their family/whanau are provided with information on the complaints process on admission. Complaint forms are available at the entrances of the service. Staff were aware of the complaints process and to whom they should direct complaints. The complaints process is in a format that is readily understood and accessible to residents/family/whanau. A complaints/compliments folder is maintained in each unit with all documentation on file. No complaints have been received for the past two years for any of the units. There is a complaints register and this has been utilised for documenting past complaints or concerns. Residents and family members advised that they are aware of the complaints procedure and how to access forms.</p> <p>D13.3h. A complaints procedure is provided to residents within the information pack at entry.</p> <p>E4.1biii. There is written information on the service philosophy and practices particular to the Janefield dementia unit included in the information pack. These include (but not limited to): a) the need for a safe environment for self and others; b) how behaviours different from other residents are managed and c) specifically designed and flexible programmes, with emphasis on minimising restraint, behaviour</p>

		management and the complaints process.
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>There is an open disclosure policy, a complaints policy, and an incident reporting policy. Residents and family members interviewed stated they were welcomed on entry and were given time and explanation about services and procedures. Resident/relative meetings occurred six weekly and the manager and clinical coordinator have an open-door policy. A sample of incident report forms sighted for October 2014 were completed and family notified as appropriate. Family notification is also recorded in progress notes and on a family contact sheet.</p> <p>D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health "Long-term Residential Care in a Rest Home or Hospital – what you need to know" is provided to residents on entry.</p> <p>D16.1b.ii: The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.</p> <p>D16.4b: The family members interviewed stated that they are informed when their family member's health status changes or of any other issues.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Birchleigh residential care centre is governed by the Board of directors of Chatsford Management Ltd. Chatsford retirement village lies adjacent to the care centre and is managed by a chief executive officer (CEO) who works across both care centre and retirement village. Within Birchleigh there are three units providing hospital, rest home and dementia level care. Each unit is managed by a nurse manager who is responsible for quality and risk management and reports to the CEO. The mission statement for company is "to be your first choice if you need aged residential care". The values of the aged care service include ensuring that each resident receives the best possible care, delivered with compassion and an obsession for excellence. Other documented values relate to staff and the facility. The care centre provides care for up to 33 rest home residents, 24 dementia residents and 24 hospital residents - with full occupancy on the day of audit. The service has a current strategic plan and a quality and risk management plan for 2014. The quality programme is managed by nurse unit managers with assistance from the CEO and the domestic services/health and safety manager. The service has an annual planner/schedule which includes audits, meetings, education and policy review time</p>

		<p>table. The monthly management team meetings include discussion on financial matters, staffing, buildings and grounds, and general business items.</p> <p>D15.3d: The CEO and the three nurse unit managers have maintained at least eight hours annually of professional development activities related to managing a rest home, hospital and dementia unit.</p> <p>E2.1 The philosophy of the service also includes providing safe and therapeutic care for residents with dementia that enhances their quality of life and minimises risks associated with their confused states.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>The service has a quality risk management plan for 2014 which has been implemented. There is an internal audit schedule and internal audits are completed for each unit. . The quality committee meets monthly to assess, monitor and evaluate quality care at Birchleigh residential care centre. There are clearly defined and measurable goals developed for the strategic plan and quality plan. The management meeting agenda and the staff meeting agenda includes (but is not limited to): complaints/concerns, audits, training, risks and hazards, health and safety, infection control, incidents/accidents, restraint, quality activities, policies and procedures. Each unit holds a three monthly staff meeting. Minutes include actions to achieve compliance where relevant. This, together with staff training, demonstrates Birchleigh's commitment to on-going quality improvement. Discussions with nurse managers, registered nurses and caregivers confirm their involvement in the quality programme. Resident/relative meetings take place three monthly in the hospital, twice a year in the dementia unit and two monthly in the rest home unit.</p> <p>Audits for 2014 have been completed and there is documented management around non-compliance issues identified. Finding statements and corrective actions have been actioned, completed and reported to the appropriate staff via meeting minutes, communication books and handover times. A six week post admission survey is conducted for all new residents, a resident satisfaction audit is conducted in each unit annually and resident and family meetings are held in each unit.</p> <p>The service has a health and safety management system and this includes the identification of a health and safety officer. Security and safety policies and procedures are in place to ensure a safe environment is provided. Emergency plans ensure appropriate response in an emergency.</p> <p>There is an infection control manual, infection control programme and corresponding</p>

		<p>policies. There is a restraint use policy and health and safety policies and procedures.</p> <p>There is an annual staff training programme that is implemented that is based around policies and procedures. Records of staff attendance are maintained. There is a document control policy that outlines the system implemented whereby all policies and procedures are reviewed regularly. Documents no longer relevant to the service are removed and archived.</p> <p>D5.4 The service has the following policies/ procedures to support service delivery; Policies and procedures align with the client care plans. Policies were reviewed by an external quality consultant. The quality committee is responsible for policy review.</p> <p>D10.1 Death/Tangihanga policy and procedure that outlines immediate action to be taken upon a consumer's death and that all necessary certifications and documentation is completed in a timely manner.</p> <p>D17.10e: There are procedures to guide staff in managing clinical and non-clinical emergencies.</p> <p>D19.3: There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management</p> <p>D19.2g: Falls prevention strategies such as falls risk assessment, walking aids, physiotherapy assessment, use of appropriate footwear, correct seating, increased supervision and monitoring and sensor mats if required.</p> <p>The service collects information on resident incidents and accidents as well as staff incidents/accidents. There is an incident/accident policy. Incident/accident forms are completed and given to the registered nurse who completes the follow up. All incident/accident forms are seen by nurse managers who complete any additional follow up and collate and analyse data to identify trends. Results are discussed with staff through the unit staff meetings, the monthly management meeting.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>There was an incident and injury investigation reporting policy which includes reporting and management of all incidents, accidents and near misses. Exception reports were completed for all incidents and accidents which were investigated and analysis of incidents trends occurred. There were discussions of incidents/accidents at monthly quality meetings and unit staff meetings including actions to minimise recurrence. Discussions with the service confirmed that there was an awareness of</p>

		<p>the requirement to notify relevant authorities in relation to essential notifications. There is an open disclosure policy and family members interviewed stated they are informed of changes in health status and incidents/accidents. Samples of incident reports for October 2014 were reviewed for residents. Caregivers commence the exception reporting form, with RN assessment and care management documented. Each unit manager completes follow up and ensures that all necessary actions have been documented and completed. Exception reporting forms sampled all evidenced that family had been notified as appropriate; assessment and care was provided by a registered nurse, appropriate referrals had been made for acute care, wound care, GP review, further care or reassessment. A record of the incidents was recorded in progress notes of the individual residents. The service has addressed and monitored this previous finding. Public Health was appropriately informed of a recent outbreak.</p> <p>D19.3b; There was an exception reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>The staff rationale policy included staffing levels, skill mix, recruitment and staff selection processes. A copy of practising certificates including the registered nurses and general practitioners was kept. There were comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Seven staff files were reviewed. Reference checks had been completed prior to the offer of employment. The service had in place a comprehensive orientation programme that provided new staff with relevant information for safe work practice. Caregivers interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. Orientation checklists evident in the staff files reviewed.</p> <p>Discussion with the CEO, nurse managers, registered nurses and caregivers confirmed that a comprehensive in-service training programme was in place that covered relevant aspects of care and support and meets requirements. An in-service programme for 2014 has been implemented. The annual training programme exceeds eight hours annually. Caregivers interviewed have either completed the ACE training programme or are working towards completion. The registered nurses are able to attend external training including conferences, seminars and sessions provided by the local DHB. The service had developed an induction/orientation programme which all staff (new and existing) had completed in the past two years. The programme included overview of the company, payroll, health and safety</p>

		<p>including incident and accident reporting, restraint minimisation, infection control and code of resident's rights. Further compulsory training sessions had been held for all staff and include health and safety, fire evacuation procedures, restraint, and infection control. The last fire drill was held on 5 August 2014.</p> <p>Annual performance appraisals had been conducted for the staff files reviewed. The service has addressed this previous finding.</p> <p>Annual competencies were completed for registered nurses and care staff with medication administration responsibilities. Competency includes completion of a written questionnaire and observation of practice. The service had addressed and monitored this previous finding.</p> <p>D17.7d: There were implemented competencies for registered nurses related to specialised procedure or treatment including (but not limited to); medication management, first aid and syringe driver training.</p> <p>4.5d the orientation programme was relevant to the dementia unit and included a session how to implement activities and therapies.</p> <p>E4.5e Agency staff received an orientation that included the physical layout, emergency protocols, and contact details in an emergency.</p> <p>E4.5f Caregivers had completed or were in the process of completing the required dementia standards.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>Staffing policy included staff rationale and skill mix. Sufficient staff were rostered on to manage the care requirements of the rest home, dementia and hospital unit residents. Registered nurses were rostered on 24/7 in the hospital unit and provided after hours and week end cover to the rest home and dementia units. Care givers, registered nurses, residents and family members interviewed advised that there were sufficient staff rostered on to provide appropriate care and services to residents. The facility has full resident occupancy at present.</p> <p>Each unit manager is responsible staff recruitment and for managing their roster - with support from administration.</p>
<p>Standard 1.3.1: Entry To Services</p>	<p>FA</p>	<p>The information pack included specific information relating to the dementia unit around the activities programme, risk management, management of challenging</p>

<p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>		<p>behaviours management and restraint minimisation. The previous audit finding has been addressed.</p>
<p>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.</p>	<p>FA</p>	<p>There were medicine management policies and procedures in place. A pharmacy contract was in place for the supply of all pharmaceuticals to the service. All medicines received were signed in and checked by the RN and unit manager in each unit, against the resident medication drug chart. All medicines were stored safely in locked treatment rooms in each of the three units. Medication trolleys are locked and stored securely when not in use. Returns to the pharmacy are kept in a locked room until collected by pharmacist. All eye drops and topical treatments were dated when opened. The medication fridges in each unit were monitored and recorded weekly. Each fridge had a thermometer in place for visual checks. An RN in the hospital unit was observed during the lunch time medication round. Correct procedures were followed. Controlled drugs were stored and administered appropriately. Two medication competent staff were evidenced as signing the CD registered and medication signing sheet. The previous audit finding has now been addressed. Allergies or nil known allergies were recorded on the medication administration sheet as evident in medication charts reviewed. All PRN medications document indicated for use.</p> <p>All medicines competent persons attended annual medication training last completed in May and August 2014. The RN's had completed an annual syringe driver competency.</p> <p>The specimen signatures list was sighted in the front of all medication folders. This was a previous audit finding that has now been addressed. There was a self-medication policy and assessment available. There were currently no residents self-medicating. Three monthly MDT reviews included medication discussion with the resident and family. Resident and families confirmed they were kept informed of medication use, changes and information.</p> <p>D16.5.e.i.2; Medication charts reviewed identified that the GP had seen and reviewed the resident three monthly and the medication chart was signed. The GP's used a medication review stamp in the medical notes in the resident files. The GP interviewed confirmed he reviewed the residents medication three monthly.</p>

<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>A food service company was contracted to provide, prepare and deliver meals out of the retirement village kitchen. The chef is fully qualified and holds certificates with London City & Guild to level four. The chef orders in all food supplies and has a tracking system in place. The dietician conducts menu reviews and all special/modified diets are met including: diabetic, pureed and soft. Resident likes and dislikes are known and alternative meals offered. Individual religious and cultural dietary needs are met. Food allergies are noted and catered for. Staff notify the chef with any resident changes in a timely manner. He attended the resident meetings and received feedback on the meals. There were specialised crockery and utensils available to promote resident independence at meal times. Residents were offered fluids throughout the day. Residents' files sampled demonstrated regular monthly monitoring of individual resident's weight. Residents interviewed were satisfied with the food service, and reported their individual preferences were met and adequate food and fluids were provided. A dietitian had input into the summer and winter four week menu – last reviewed October 2014. The dietitian also provided input into the resident's weight management and special diets required to maintain weight such as dietary supplements and drinks.</p> <p>Each unit within Birchleigh has a kitchen area where hot meals were delivered in hot boxes. Hot food temperatures were monitored daily with food being held in bain maries until served. Fridge and freezer monitoring was done weekly. All perishable foods in fridges were dated and labelled. Food handling staff were observed wearing aprons, hats and gloves. The afternoon kitchen hand and night shift staff carry out cleaning duties. Cleaning schedules were in place and implemented. Residents and relatives interviewed were complimentary regarding food services.</p> <p>E3.3f, There is evidence that there was additional nutritious snacks available over 24 hours with food available in the dementia unit such as sandwiches, ice-cream, yoghurt biscuits, fruit and other appetising "finger foods".</p> <p>D19.2: All food handling staff had been trained in safe food handling Unit 167 last completed August 2014.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Resident files were reviewed and the files identified that initial nursing assessment and care plans were completed within 24 hours and all files identified that the long term care plan was completed within three weeks. There was documented evidence that the care plans were reviewed by the registered nurses and amended when current health changed. Care plans evidenced evaluations completed at least six</p>

	<p>monthly. Activity assessments and the activities care plans were completed by the diversional therapist or activities coordinator. The care being provided was consistent with the needs of residents. This was evidenced by discussions with residents, families, caregivers, registered nurses and unit managers. A review of short term care plans, long term care plans, evaluations and progress notes demonstrated integration. There was evidence of three monthly medical reviews.</p> <p>The use of risk tools identified the need for interventions, equipment, products and referrals to meet the needs, goals and outcomes for the resident. On interview the GP confirmed that he was notified promptly when his patients health status had changed and stated the clinical staff were experienced in assessing residents and reporting appropriately.</p> <p>The Southern District Heath Board psycho-geriatric nurse practitioner visits two weekly and provides support and education for the unit managers, staff, and families on behavioural problems and management. She is available for all the units but predominantly the dementia unit and families on a one to one basis. The nurse practitioner initiates referrals to the GP and liaises with the psychogeriatric team daily.</p> <p>Mobility aids required to meet the mobility needs and safety of residents assessed needs were available and referrals made to the physiotherapist as needed.</p> <p>D18.3 and 4: There were adequate dressing supplies and a range of products available.</p> <p>Continence products were available and resident files included a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice was available as needed and this could be described.</p> <p>Continence management in-services and wound management in-service had been provided.</p> <p>Wound management plans were in place for residents. There were no wounds currently in the dementia unit. There were no pressure areas. Wounds included skin tears, pustules and lesions. All wounds had short term care plans developed with ongoing treatment and evaluation documented. There were no wound assessments completed (# link 1.3.3.1).</p> <p>The RNs and unit managers interviewed described the referral process should they require assistance from a wound specialist or continence nurse. Additional resources and products were readily available on request.</p>
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<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The diversional therapist (DT) worked 35 hours/week and has been at the service for 12 years. There was also an activities coordinator who worked 25 hours per week. The DT and activities coordinator deliver an activities programme that was appropriate to the setting of the service and meets the individual abilities. Both staff work in the rest home, hospital and dementia care units. There was an activities person on duty in the weekends. The DT and activities coordinator attended two workshops a year and local monthly activity meetings. There were three programmes developed monthly appropriate for rest home, hospital and residents in the dementia unit. Rest home residents enjoy group activities such as but not limited to: lounge hockey, newspaper reading, exercises, cards, housie, and happy hour. Hospital residents enjoy individual time with the activities person including but not limited to: nail care, hand massage, craft, game of cards, ball games. The programme is flexible to meet the individual ability and resident choice. Activities for resident in the dementia unit were person centred, flexible and timed to meet identified individual behaviours such one to one walks, reminiscing, photo books. Sing-alongs and entertainment was enjoyed as were drives to the country. The caregivers and activities persons ensured activities were provided over a 24 hour period as required. Separate daily activity summary were maintained by the carer and activities person.</p> <p>A minister of religion visits and there were two volunteers that assisted with activities</p> <p>All residents may attend entertainment. Outings were planned and there were two vans available, one with wheelchair access. Both activities staff had current first aid certificates.</p> <p>Special occasions and festivities were celebrated and church services were held weekly and on Sundays. Residents were encouraged to maintain community links which included the church, library, age concern, community quizzes at other facilities, community concerts, community games, RSA visits, visits to the facility from school children and preschool children. Resident activities were observed in the rest home, hospital and dementia care unit.</p> <p>Each resident had a personal profile, past and present activities and interests, evaluation and progress notes. The resident and/or their family were involved in the activity care plan. There was a wide range of activities offered that reflected the resident needs. Participation in all activities was voluntary. Residents and families interviewed confirmed that they were involved in the activity care plan and were able to provide feedback and suggestions on the programme.</p>

		<p>There are two monthly resident meetings with an opportunity to provide feedback and suggestions on the activity programme.</p> <p>D16.5d Resident files reviewed identified that the individual activity plan was reviewed when at care plan review.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Care plans were evaluated at least six monthly and when there was a change in the health status of the resident. Residents' files sampled evidence that evaluations of care plans were within stated timeframes and reviewed more frequently if a resident's condition changed. The GP reviewed residents' medical condition and medication charts every three months. Evaluations were conducted by the RNs with input from the resident, family, care givers, and GP. Family were notified of any changes in resident's condition, evidenced in residents' files sampled. Residents interviewed confirmed their participation in care plan evaluations and this was evidenced in the files reviewed. Risk assessment tools were evaluated at the time of care plan review or earlier if there was an increase in risks identified for the resident. Short term care plans were evaluated regularly with any ongoing needs being included in the six monthly reviews. Short term care plans evidenced (currently active and resolved) included urinary infections, chest infections, skin rashes, challenging behaviours, fractures and lesion excisions.</p> <p>D16.4a Care plans were evaluated six monthly and more frequently when clinically indicated.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The service displays a current building warrant of fitness which expires on 3 March 2015.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Infection surveillance was part of the infection control programme and was described in the infection control manual. The unit manager of the dementia unit is the infection control coordinator. Monthly infection data is collected for all infections based on signs and symptoms of infection and entered on a monthly infection summary. An individual resident infection form is completed which included signs and symptoms of infection, treatment, follow up, review and resolution. This data was monitored and evaluated monthly and annually. Outcomes and actions were discussed at the</p>

		<p>monthly management meetings, and monthly staff meetings. If there was an emergent issue, it was acted upon in a timely manner. Reports were easily accessible to the unit managers and CEO. Infection surveillance data was gathered as per standard definitions for infections. The service benchmarked data for infection rates. A recent outbreak was appropriately managed and contained. Relevant authorities were notified in a timely manner.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Documented systems were in place to ensure the use of restraint was actively minimized. There were 10 hospital residents with enablers and two hospital residents with restraint. Approved enablers and restraint included; bed rails, attached chair tables and lap belts. Staff interviews and staff records evidenced training had been provided on restraint minimisation, enabler usage and prevention and/or de-escalation techniques. Policies and procedures included definition of restraint and enabler that were congruent with the definition in NZS 8134.0. Restraint minimisation policies were reviewed in 2014. Restraint and enabler files were sampled with appropriate documentation completed.</p> <p>Restraint use and review meetings were held four times per year and the agenda included policy review, enabler and restraint use, training, audits and goals for the year.</p> <p>E4.4a: The care plans reviewed focused on promotion of quality of life and minimised the need for restrictive practises through the management of challenging behaviour.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.3.1</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function.</p>	PA Low	<p>Wounds reviewed all had a short term care plan developed with ongoing treatment plans and combined assessments/evaluations completed.</p> <p>Wound care plans reviewed did not include the completion of a separate wound assessment form for each individual wound. The service advised that they are in the process of implementing an improved form for documenting wound assessments.</p>	<p>Overall wound assessments are currently completed initially and through the ongoing evaluation process. The tracer resident with a wound did not have a wound assessment form completed, but wound evaluation and treatment was documented in the progress notes.</p>	<p>Ensure that all wounds have a separate wound assessment form completed</p> <p>90 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.