

Birchleigh Management Limited - Birchleigh Residential Care Centre

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](#).

The specifics of this audit included:

Legal entity:	Birchleigh Management Limited
Premises audited:	Birchleigh Residential Care Centre
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 9 May 2016 End date: 10 May 2016
Proposed changes to current services (if any):	Addition of medical service to their current hospital certification. Addition of a hospital level room in the hospital unit

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
	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

Birchleigh Residential Care Centre is certified to provide rest home, dementia and hospital – geriatric level care for up to 83 residents. On the day of audit, there were 81 residents. The service is overseen by a chief executive officer who reports to a Board of Directors. Each unit is managed by an experienced nurse manager (registered nurse).

Residents and families interviewed were complimentary of the service that they receive. Staff turnover has been low.

This certification audit was conducted against the Health and Disability Service Standards and the district health board contract. The audit process included a review of policies and procedures, the review of resident and staff files, observations and interviews with residents, family members, staff and management. This audit also included verifying the service as appropriate to provide hospital – medical care.

The service has exceeded the standard in relation to reduction of restraint use.

The audit has identified that improvements are required around incident reporting, care plan timeframes, wound care documentation, medication management, and preventative maintenance schedule.

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 staff ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. 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). Information about the Code and services is easily accessible to residents and families. Information on informed consent is provided and discussed with residents and relatives. Staff interviewed are familiar with processes to ensure informed consent. Complaints policies and procedures meet requirements and residents and families are aware of the complaints process.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Organisational performance is monitored through a number of processes to ensure it aligns with the identified values, scope and strategic direction. The business plan has goals documented. There are policies and procedures that support and guide staff providing care to residents with rest home, hospital and dementia level needs. There is an implemented quality and risk management programme.

Staff receive ongoing training and there is an implemented 2016 training plan. Rosters and interviews indicate sufficient staff that allows flexibility of staffing around client's needs.

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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Entry to the service is managed by the three nurse managers and registered nurses. There is comprehensive service information available. Assessments, care plans and evaluations are completed by a registered nurse. Each resident has access to an individual and group activities programme. The group programme is varied and interesting. Medication is stored appropriately in line with legislation and guidelines. General practitioners review residents at least three monthly or more frequently if needed. Meals are prepared on-site by a contracted company. The menu is varied and appropriate. Individual and special dietary needs are catered for. Alternative options are provided. Residents and relatives interviewed were complimentary about the food service.

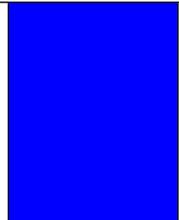
Safe and appropriate environment

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.		Some standards applicable to this service partially attained and of low risk.
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Chemicals are stored safely throughout the facility. Appropriate policies are available along with product safety charts. The building holds a current warrant of fitness. Resident rooms are spacious with an adequate number of shower and toilet facilities for the number of residents. There is wheelchair access to all areas. External areas are safe and well maintained. Fixture, fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are well monitored through the internal auditing system. Appropriate training, information and equipment for responding to emergencies are provided. There is an approved evacuation scheme and emergency supplies for at least three days. All staff hold a current first aid certificate.

This audit verified that an additional hospital level room is appropriate for hospital level care residents.

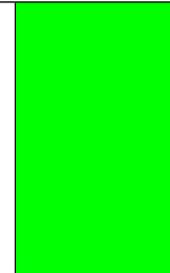
Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		All standards applicable to this service fully attained with some standards exceeded.
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Birchleigh has restraint minimisation and safe practice policies and procedures in place. Staff receive training in restraint minimisation and challenging behaviour management. The service has achieved a restraint-free environment. Three hospital residents had bedrail enablers.

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.

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and as part of the ongoing in-service education programme. 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.

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	39	0	5	0	0	0
Criteria	1	87	0	5	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 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) poster is displayed in a visible location. The policy relating to the Code is implemented and staff can describe how the Code is incorporated in their everyday delivery of care. Interviews with staff (nine caregivers, two registered nurses, three nurse managers and two diversional therapists), reflected their understanding of the key principles of the Code.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Informed consent, advanced directives and medical care guidance instructions were recorded, as evidenced in nine resident files reviewed (three rest home, three dementia and three hospital). Dementia residents have an activated enduring power of attorney in place (EPOA). There was evidence that family involvement occurs with the consent of the resident. Family members/EPOA interviewed confirmed that information was provided to enable informed choices and that they were able to decline or withdraw their consent. Resident admission agreements were signed. Caregivers and the registered nurses interviewed confirmed verbal consent is obtained when delivering care. Nine of nine resident files sampled had a signed admission agreement.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>All residents have a documented enduring power of attorney on file (EPOA) if they cannot self-advocate. Contact numbers for advocacy services are in advocacy pamphlets that are available in the entrance. Residents' meetings include actions taken (if any) before addressing new items. Discussions with relatives identified that the service provides opportunities for the family/EPOA to be involved in decisions.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Residents and relatives confirmed that visiting can occur at any time. Key people involved in the resident's life have been documented in the resident files. Residents verified that they have been supported and encouraged to remain involved in the community. Entertainers are regularly invited to perform at the facility.</p>
<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>A complaints policy and procedure has been implemented and residents and their family/whānau are provided with information on admission.</p> <p>Each of the three units had the complaints policy posted in a visible area with complaints forms and advocacy information nearby. The residents and families interviewed from each of the three units were aware of the complaints process and to whom they should direct complaints.</p> <p>None of the three units had complaints for 2016; complaints reviewed (which were of a low level) for 2015 demonstrated comprehensive investigation and responses to the complainant.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>The service provides information to residents that include the Code, complaints and advocacy including in formats suitable for people with intellectual disabilities. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Thirteen residents (nine rest home and four hospital) and eleven relatives (four rest home, three hospital and four dementia unit) interviewed identified they are well-informed about the Code. Resident meetings in each of the three units and surveys provide the opportunity to raise concerns. Advocacy and Code of Rights information is included in the information pack and are available at the service.</p>

<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Staff interviewed were able to describe the procedures for maintaining confidentiality of resident records, resident's privacy and dignity. Residents are supported to attend other churches if they wish. Residents and relatives interviewed reported that residents are able to choose to engage in activities and access community resources. There is an abuse and neglect policy and staff education has been provided.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>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.</p>	FA	<p>The service has a Māori health plan and an individual's values and beliefs policy which includes cultural safety and awareness. Tikaka best practice guidelines are available to staff. Residents who identify as Māori have their cultural needs addressed in care plans. Discussions with staff confirmed their understanding of the different cultural needs of residents and their whānau. Interviews with staff confirmed they are aware of the need to respond appropriately to maintain cultural safety. The service has links to the DHB for cultural support as needed and is working towards establishing cultural links with the Otago University Māori liaison unit. Cultural training is included in the bi-annual training for staff.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Care planning and activities goal setting includes consideration of spiritual, psychological and social needs. Residents and family members interviewed indicated that they are asked to identify any spiritual, religious and/or cultural beliefs. Relatives reported that they feel they are consulted and kept informed and family involvement is encouraged.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>There are policies and procedures for staff around maintaining professional boundaries and code of conduct. The employment agreement includes a code of conduct. Job descriptions include responsibilities of the position. Interviews with caregivers confirmed their understanding of professional boundaries, including the boundaries of the caregivers' role and responsibilities. Professional boundaries are reconfirmed through education and training sessions, staff meetings and performance management if there is infringement with the person concerned.</p>

<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service meets the individualised needs of residents with needs relating to aged care. The quality programme has been designed to monitor contractual and standards compliance and the quality of service delivery in the facility. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training.</p> <p>Residents and relatives interviewed spoke very positively about the care and support provided.</p> <p>The service has seven registered nurses assessed as interRAI competent and 91% of all care hours are delivered by caregivers with at least level one ACE qualification. Four staff have attended the 'Walking in Another's Shoes' training and have credited this training with improvements to care and support in the dementia unit and other areas.</p> <p>Restraint use and infection levels remain low and staff report that this is due to raised awareness and training.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Relatives interviewed stated they are informed of changes in health status and incidents/accidents. This was confirmed on incident forms reviewed. Residents also stated they were welcomed on entry and were given time and explanation about services and procedures. Resident meetings occur in each of the three units. Residents and family are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The service has policies and procedures available for access to interpreter services for residents (and their family). If residents or family/whānau have difficulty with written or spoken English, then interpreter services are made available.</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>	<p>FA</p>	<p>Birchleigh Management Limited (Birchleigh) provides residential services for up to 83 residents requiring rest home, hospital – geriatric and dementia level care. On the day of the audit there were 81 residents, all under the Aged Residential Care contract. There were 25 residents in the hospital unit – 24 hospital and one rest home; 33 residents in the rest home; and 23 residents in the dementia unit.</p> <p>The goals and direction of the service are well documented in the business plan and the progress toward previous goals has been documented through reports to the boards, staff meeting and staff communication leaflets monthly.</p> <p>The organisation is managed by the CEO, a non-clinical person who has been in the role for nine years. The CEO reports to a board of directors. The CEO has maintained eight hours annually of professional development activities related to managing an aged care facility. Each of the three units is managed</p>

		<p>separately by an experienced nurse manager, all of whom are registered nurses.</p> <p>The service has appropriate staffing, allied health input and equipment to add medical to their current hospital certification.</p> <p>One additional hospital room was reviewed; this room is appropriate for up to two residents. It currently has a married couple and there is room for mobility aids.</p>
<p>Standard 1.2.2: Service Management</p> <p>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.</p>	FA	<p>The CEO reported that in the event of his temporary absence, the board would maintain oversight and the three nurse managers would provide clinical management as usual. The nurse managers provide oversight for each other as needed.</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>	FA	<p>Quality improvement processes are in place to capture and manage non-compliances. They include internal audits, hazard management, risk management, incident and accident, infection control data collection and complaints management. All quality improvement data is discussed at three monthly staff meetings in each unit and monthly at the senior management quality meetings. Meeting minutes reviewed evidenced that there is good communication and feedback to staff and management around quality outcomes and KPIs. Each of the nurse managers facilitates the quality programme in their own unit and ensures the internal audit schedules are implemented. The internal audit schedule is implemented in all three units. Corrective action plans are developed, implemented and signed off when service shortfalls are identified.</p> <p>Monthly trend analysis is posted up in staff rooms and document infection control graphs and incident/accident graphs such as falls, skin tears and bruises.</p> <p>There are policies and procedures that are relevant to the various service types offered and are reviewed two yearly. These have been updated to include interRAI requirements.</p> <p>There is a current risk management plan. Hazards are identified, managed and documented on the hazard register. Health and safety issues are discussed at monthly staff meetings, quality meetings and reported monthly to the board. Action plans were documented to address issues raised.</p> <p>There are resident surveys conducted and analysed with corrective action plans developed when required. The 2015 resident survey demonstrated a high level of satisfaction with the service.</p>

		Falls prevention strategies are in place for individual residents.
<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>	PA Low	<p>The accident/incident process (exception reports) includes documentation of the incident and analysis and separation of resident and staff incidents and accidents.</p> <p>Resident exception reports for April were reviewed for each of the three units. All three units had exception reports that were incomplete and did not have a fully completed RN review of the incident on the form. One pressure injury did not have an associated incident form (exception report).</p> <p>Accidents and incidents are analysed monthly with results discussed at monthly quality meetings and three monthly staff meetings.</p> <p>The nurse managers were aware of situations that require statutory reporting.</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>	FA	<p>Nine staff files were sampled, (one nurse manager and one caregiver for the dementia unit, one nurse manager and two caregivers from the rest home, one nurse manager and two caregivers from the hospital and one laundry person). All documented appropriate employment practices and documented annual appraisals as needed and current job descriptions. Current annual practising certificates are kept on file.</p> <p>There is a fully implemented and comprehensive training plan in place. There are implemented competencies for registered nurses related to specialised procedure or treatment including (but not limited to): medication management and syringe driver training and competencies. Residents and families state that staff are knowledgeable and skilled.</p> <p>Staff who work in the dementia unit have completed the dementia unit standards with the exception of two recently employed staff.</p> <p>Staffing in the hospital unit can accommodate the additional room. Registered nurses receive training to ensure that residents who are funded under the medical component will receive appropriate care (such as medication, oxygen therapy and syringe driver training).</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled</p>	FA	<p>There is a documented rationale for staffing the service. Staffing rosters were sighted and staff are on duty to match needs of different shifts and needs of different individual residents. The nurse managers are on-call after-hours, with other registered nurses. Adequate RN cover is provided 24 hours a day, 7 days a week. Sufficient numbers of caregivers support RNs. Interviews with the residents and relatives confirmed staffing overall was satisfactory.</p>

and/or experienced service providers.		
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The service retains relevant and appropriate information to identify residents and track records. Files and relevant resident care and support information can be accessed in a timely manner.</p> <p>All resident files are in hard copy and stored where they cannot be accessed by people not authorised to do so.</p> <p>Individual resident files demonstrate service integration. Medication charts are in a separate folder with medication and this is appropriate to the service.</p> <p>Entries are legible, dated and signed by the relevant staff member including designation.</p>
<p>Standard 1.3.1: Entry To Services</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>	FA	<p>The service has admission policies and processes in place. Residents and family members receive an information pack outlining services able to be provided, the admission process and entry to the service. The nurse managers of each unit screen all potential residents prior to entry and record all admission enquiries. Residents and family members interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the nurse managers. The admission agreement form in use aligns with the requirements of the ARC contract. Exclusions from the service are included in the admission agreement. The information provided at entry includes examples of how services can be accessed that are not included in the agreement.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs. Relatives interviewed confirmed they were kept well informed about all matters pertaining to residents, especially if there is a change in the resident's condition.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative</p>	PA Low	<p>The medication management policies and procedures comply with medication legislation and guidelines. Medicines are appropriately stored in accordance with relevant guidelines and legislation. Medication administration practice complies with the medication management policy for the medication rounds sighted. Medication prescribed is signed for correctly for the sample of medication charts reviewed in the rest home and dementia units. The caregivers administer medicines in the rest home and dementia units. Registered nurses administer medications to hospital residents. Staff who administer medication have been assessed</p>

<p>requirements and safe practice guidelines.</p>		<p>as competent. The facility uses a blister pack medication management system for the packaging of all tablets. The RN's reconcile the delivery and this is documented. Medication charts are written by medical practitioners and there was evidence of three monthly reviews by the GP. Not all medications are prescribed and charted in line with guidelines. There were no residents self-administering medicines. Standing orders are in place in the hospital unit only and these are current.</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>The food service at Birchleigh Residential Care Centre is provided by a contracted company. The kitchen is located at the adjacent retirement village and transported across to the facility in hot boxes. The meals are served to residents from small kitchens (one in each of the three units), which are located beside each dining room. Bain maries are used in each servery to ensure that food is served hot. The operations manager and the kitchen manager oversee the food service. Food service manuals are in place to guide staff. A resident dietary profile is developed for each resident on admission and is provided to the kitchen staff. The kitchen is able to meet the needs of residents who need special diets and the cooks work closely with the registered nurses. Kitchen staff have completed food safety training. The cooks follow a rotating menu, which has been reviewed by a dietitian. The temperatures of refrigerators, freezers and cooked foods are routinely monitored and recorded. There is special equipment available for residents if required. All food is stored appropriately. Residents and the family members interviewed were very happy with the quality and variety of food served. The dementia unit is supplied with extra nutritious snacks for residents.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>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.</p>	<p>FA</p>	<p>The service records the reason for declining service entry to residents should this occur and communicates this decision to residents/family/whānau. Anyone declined entry is referred back to the referring agency for appropriate placement and advice.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>All nine files sampled evidenced that appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. This forms the basis of the initial care plan. All nine resident files sampled evidenced that the interRAI assessment tool had been used to form the basis of the long-term care plan. The interRAI assessment outcomes were reflected in the long-term care plans reviewed. Six monthly interRAI reassessment has occurred for seven of nine residents. Two residents were admitted within the previous six months and interRAI was not yet required to be reviewed. Risk</p>

		assessment tools are used where required.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>The long-term care plans reviewed described areas of the support required to meet the resident's goals and needs and identified allied health involvement under a range of template headings. Residents and their family/whānau are documented as involved in the care planning and review process. Short-term care plans were in use for changes in health status. Staff interviewed reported they found the plans easy to follow.</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>	PA Low	<p>Caregivers follow the care plan and report progress against the care plan each shift. If external nursing or allied health advice is required the RNs will initiate a referral (e.g., to the district nurse). If external medical advice is required, this will be actioned by the GP. Staff have access to sufficient medical supplies (e.g., dressings). Sufficient continence products are available and resident files include a continence assessment and plan. Specialist continence advice is available as needed and this could be described.</p> <p>Monitoring forms sighted were in place for enabler use, behaviour management, fluid balance charts, turning charts and pain management.</p> <p>Wound documentation is available and includes assessments, management plans, progress and evaluations. In the rest home there were three residents with five wounds. One resident has a chronic leg ulcer and a skin tear; one resident has a graze and a skin tear; and one resident has had a skin cancer removed. There were no current wounds in the dementia unit. In the hospital there was wound documentation in use for four residents with seven wounds. One resident has four skin tears; one resident has an infected leg wound; and two residents have skin tears. During the audit it was identified that one hospital resident has a stage II pressure injury which is being dressed, however this has not been documented. The RNs have access to specialist nursing wound care management advice through the district nursing service.</p>
<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>	FA	<p>Two activities staff members facilitate the activities programme for all residents. One staff member is a diversional therapist and one is a trained teacher. Each resident has an individual activities assessment on admission and from this information, an individual activities plan has been developed by the activities staff for the nine resident files sampled. The two staff members divide their time between the three units. Each unit has a separate programme and reflects the resident's cognitive and physical abilities. Activities in the dementia unit are provided for each morning and afternoon. Caregivers are also involved in the programme in the dementia unit.</p> <p>Each resident is free to choose whether they wish to participate in the group activities programme or their</p>

		individual plan. Participation is monitored. Group activities reflect ordinary patterns of life and include planned visits to the community. Residents and families interviewed commented positively on the activity programme.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	All initial care plans are evaluated by the registered nurses within three weeks of admission. The long-term care plan is reviewed at least six monthly or earlier if there is a change in health status. Reviews document progress toward goals. There is at least a three monthly review by the GP. Changes in health status are documented and followed up. Care plan reviews are signed by an RN. Short-term care plans are evaluated and resolved or added to the long-term care plan if the problem is ongoing as sighted in resident files sampled. Where progress is different from expected, the service responds by initiating changes to the care plan.
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 services. Referral documentation is maintained on resident files. The nurses initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs. Referrals and options for care were discussed with the family as evidenced in interviews and medical notes. The staff provided examples of where a resident's condition had changed and the resident was reassessed.
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	All chemicals were securely stored. Chemicals were clearly labelled and safety material data sheets were available and accessible in all service areas. The hazard register is current. Staff interviewed confirmed they can access personal protective clothing and equipment at any time. As observed during the audit, staff were wearing gloves, aprons and hats when required. The dementia unit staff were noted to be particularly vigilant around chemical safety.

<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>	<p>PA Low</p>	<p>There are established systems in place to ensure the physical environment and facilities are safe and fit for their purpose. The facility has a current building warrant of fitness which expires on 3 March 2017.</p> <p>Maintenance is undertaken by both internal maintenance personnel and external contractors. Electrical safety test tag system shows this has occurred. The facility is being maintained in good repair. All maintenance records were reviewed and are clearly documented. The maintenance records were reactive maintenance. There was no documented preventative maintenance schedule. Water temperatures are monitored. It was identified that whenever it was out of range, corrective actions had not been taken.</p> <p>The wide corridors and rails promote safe mobility with the use of mobility aids and transferring equipment. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens are well maintained. There is outdoor furniture and seating and shaded areas. There is safe wheelchair access to all communal areas. There is an outdoor designated smoking area.</p> <p>The caregivers and RNs interviewed stated that they have all the equipment referred to in care plans necessary to provide care.</p> <p>The dementia unit lounge area is designed so that space and seating arrangements provide for individual and group activities. Seating is appropriate and designed to meet the consumer group. There are quiet, low stimulus areas that provide privacy when required. There is a safe and secure outside area that is easy to access.</p> <p>The service has added a hospital level room. The room was noted to be large enough for the care of a resident and associated mobility equipment. There is heating and an external window. The room currently accommodates a married couple.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>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.</p>	<p>FA</p>	<p>All bedrooms have access to hand basins. Not all rooms have ensuites. There are adequate numbers of communal toilets and shower rooms. There are communal toilets located close to communal areas in the rest home and hospital areas. Not all toilets have privacy locks, engaged/vacant signs are in use. There is appropriate signage, easy clean flooring and fixtures and handrails appropriately placed. Residents interviewed report their privacy is maintained at all times.</p>

<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>There is adequate space in the bedrooms and enough space for the safe manoeuvring of mobility equipment. Residents can personalise their rooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>The rest home area has a separate dining area which is set out to encourage social interaction at meal times. The dining room chairs are easy slide chairs which are manageable for the consumer group. There is a separate lounge area suitable for entertainment and several smaller lounge areas with seating placed to provide quiet private areas for residents and their families. There is a quiet library/reading area. There is also an alcove area with a portable phone available for private telephone conversations.</p> <p>The hospital area provides a spacious open plan dining and lounge area that meets the needs of the consumer and observational requirements for care staff. There is adequate space for activities persons to provide a group activity. There is a family/whānau lounge available for private family visits, GP meetings and family meetings. There are sofa beds in the room for family to stay overnight if desired.</p> <p>The dementia care unit layout provides for freedom of movement within a safe and secure environment. There are external walking paths and internal space to allow wandering that is not obtrusive on other residents. There is sufficient space within the open plan dining and lounge area to accommodate individual low stimulus activities and group activities. Resident dining can be easily observed and supervised. All communal areas can be observed from the nurses' station.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>There are cleaning and laundry policies and procedures in place. The domestic services officer oversees the areas and is responsible for procurement and health and safety. Housekeeping staff are responsible for cleaning and laundry service. There are sufficient staff allocated seven days a week to carry out these services. All laundry and personal clothing is laundered on-site. There are defined clean/dirty areas. Cleaner's trolleys are stored in locked areas when not in use. There were adequate linen supplies sighted in the facility linen-store cupboards. Internal audits monitor the effectiveness of laundry and cleaning processes.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p>	<p>FA</p>	<p>The service has an approved evacuation plan. Fire evacuation drills are held six monthly. Civil defence equipment and resources are available and this was discussed with the maintenance person responsible. A gas barbecue is also available. The facility has back up lighting, power and sufficient food, water and</p>

<p>Consumers receive an appropriate and timely response during emergency and security situations.</p>		<p>personal supplies to provide for its maximum number of residents in the event of a power outage.</p> <p>The emergency plans and security systems meet regulation requirements. The nurse call system is appropriate for the size of the facility and call bells are accessible in the rooms, lounge and dining areas.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>The communal areas and bedrooms have adequate natural light with large windows and in some rest home rooms there are ranch sliders to the outdoors. There are a variety of heating methods used to maintain a warm environment within the communal areas and bedrooms including heat pumps and under floor heating. The temperature is thermostat controlled and can be individually adjusted in the resident bedrooms. Residents and families interviewed advised that the bedrooms, lounges and other communal rooms are warm and comfortable.</p>
<p>Standard 3.1: Infection control management</p> <p>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.</p>	<p>FA</p>	<p>Birchleigh has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. The dementia unit nurse manager is the designated infection control nurse with support from the other nurse managers and registered nurses. Audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The infection control programme has been reviewed annually.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The dementia unit nurse manager at Birchleigh is the designated infection control (IC) nurse. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurse and IC team (comprising staff representatives) has external support from the local laboratory infection control team and IC nurse specialist at the DHB. 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.</p>
<p>Standard 3.3: Policies and</p>	<p>FA</p>	<p>There are infection control policies and procedures appropriate for the size and complexity of the service. The infection control manual outlines a range of policies, standards and guidelines and includes defining</p>

<p>procedures</p> <p>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.</p>		<p>roles, responsibilities and oversight, the infection control team and training and education of staff. The policies were developed by the IC nurse and IC team and have been reviewed and updated.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred. The infection control nurse has completed infection control training. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records.</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>	<p>FA</p>	<p>Infection surveillance is an integral part of the infection control programme and is described in Birchleigh infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed which includes signs and symptoms of infection, treatment, follow up, review and resolution. Surveillance of all infections is entered on to a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at staff meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the nurse managers. Since the previous audit there has been one outbreak, which was reported and appropriately managed.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively</p>	<p>CI</p>	<p>The service has documented systems in place to ensure the use of restraint is actively minimised. There were three hospital residents with enablers in use. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. Enablers are voluntary. Enabler documentation for three files reviewed includes consent, risk assessments, care planning, monitoring and review. Staff education on RMSP /enablers has been provided at least twice a year and on orientation of</p>

minimised.		new staff. The service has reduced the use of restraint over the past five years and is now restraint-free.
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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 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	PA Low	<p>Policy and procedures guide staff around incident and accident reporting. The exception reporting template is available to staff and incidents are recorded on this form. Three monthly staff meetings, monthly quality meetings and monthly reports to the board document that the service actively reviews and discusses incidents and accidents. Exception reports reviewed were not all fully completed and one pressure injury had no exception report completed.</p> <p>Hospital exception reports included three falls, one choking episode, four behaviour incidents (one resident) and one skin tear reviewed. Dementia exception reports included one behavioural incident and twelve falls. Rest home exception reports included five falls and two skin tears.</p>	<p>Five of nine hospital incident reports reviewed did not document a complete RN review and follow up. One hospital level resident with a pressure injury did not have an incident report completed. Ten of twelve dementia incident reports did not document a complete RN review and follow up and four of seven rest home incident reports did not document a complete RN review and follow up.</p>	<p>Ensure all pressure injuries have an exception report completed. Ensure that exception reports are fully completed including record of registered nurse follow</p>

				up. 90 days
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	PA Low	<p>Eighteen medication charts were reviewed for six rest home, six dementia and six hospital residents. Medications requiring controls were noted to be stored and registered in line with legislation. Two staff signatures were noted on administration signing sheets for rest home and dementia residents. Only one staff member (registered nurse) had been signing on administration sheets for hospital resident controlled drug medication. Warfarin orders are received from the medical practice. Not all orders have a medication order signed for by the GP.</p>	<p>i) Only one staff member is signing for controlled drug administration in the hospital unit; and ii) medication orders for residents receiving variable doses of warfarin are not always signed by the prescriber.</p>	<p>i) Ensure that controlled drug administration and signing aligns with guidelines and best practice; and ii) ensure that all medication orders are signed by the prescriber.</p> <p>30 days</p>
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	PA Low	<p>Residents in the sample have been assessed with the interRAI assessment tool within the required timeframes. Long-term care plans have been developed within twenty-one days for seven of nine resident files reviewed. Long-term care plan evaluations have been conducted six monthly or more frequently as required.</p>	<p>The long-term care plan was developed after the 21 day timeframe for one rest home and one dementia resident.</p>	<p>Ensure that long-term care plans are developed within the required timeframes.</p> <p>90 days</p>
<p>Criterion 1.3.6.1</p> <p>The provision of</p>	PA Low	<p>Wound documentation reviewed included wound assessments, wound care plans and progress notes. The progress notes record the current wound dressings and how well the wound is</p>	<p>One resident with a stage 2 pressure injury did not have wound documentation</p>	<p>Ensure that wounds care plans are</p>

<p>services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>		<p>healing. The service photograph wounds if required to monitor progress. Wound and skin specialist input was also evidenced as having been accessed when required. A stage II pressure injury was identified through review of one hospital resident's progress notes and medical file entries. There was minimal reference to the pressure area and reposition of the resident in progress notes. The GP had been made aware of the injury in March and had reviewed the area in April. The care plan included skin care and repositioning of the resident.</p>	<p>completed. The injury had been identified by nursing staff, but was not adequately documented or reported to the nurse manager.</p>	<p>developed for all wounds, including pressure injuries and that these are identified and reported to management.</p> <p>30 days</p>
<p>Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.</p>	<p>PA Low</p>	<p>Maintenance is undertaken by both internal maintenance personnel and external contractors. Electrical safety test tag system shows this has occurred. The facility is being maintained in good repair. All maintenance records were reviewed and are clearly documented. The maintenance records were reactive maintenance. There was no documented preventative maintenance schedule. Water temperatures are monitored. It was identified that whenever it was out of range, corrective actions had not been completed.</p>	<p>There was no documented preventative maintenance schedule. Water temperatures are monitored. It was identified that whenever it was out of range, corrective actions had not been completed.</p>	<p>Document and implement an annual preventative maintenance schedule; (ii) Ensure corrective actions are documented when water temperatures are above 45 degrees.</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, 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
<p>Criterion 2.1.1.4</p> <p>The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.</p>	CI	<p>Restraint and enabler use is a clinical indicator which is monitored each month. The service has actively reduced the use of restraints and enablers.</p>	<p>The hospital nurse manager is the restraint coordinator and has been in the role for the past five years.</p> <p>In 2011, the restraint coordinator identified a high level of restraint use - with 19 of 24 hospital residents with some form of restraint in place. Restraint and enabler reduction goals and objectives have been set and reviewed each year. The intention has been to minimise restraint and enabler use and to ensure that staff are educated in restraint minimisation. Restraint use data has been gathered each year and reviewed at clinical and quality meetings.</p> <p>Since 2011, the use of restraint has been reduced by approximately 50% each year. The service now has no residents with restraint and this has been maintained for the past 18 months. Enabler use has been reduced from eight enablers in 2012 to three hospital residents with enablers in 2016.</p>

End of the report.