

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: 6 May 2019 End date: 7 May 2019
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:	78



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 78 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.

The service has exceeded the standard around good practice.

The audit has identified that improvements are required around progress note 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.

All standards applicable to this service fully attained with some standards exceeded.

Policies and procedures adhere with the requirements of the Code of Health and Disability Services Consumers' Rights (the Code). Residents and families are informed regarding the Code and staff receive ongoing training about the Code.

Personal privacy and values of residents are respected. Individual care plans reference the cultural needs of residents. Discussions with residents and relatives confirmed that residents and where appropriate their families are involved in care decisions. Regular contact is maintained with families including if a resident is involved in an incident or has a change in their current health. Families and friends are able to visit residents at times that meet their needs. 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.

Standards applicable to this service fully attained.

Services are planned, coordinated, and are appropriate to the needs of rest home, hospital and dementia level care residents. A chief executive, a services manager and three nurse managers are responsible for the day-to-day operations. Goals are documented for the service with evidence of regular reviews. A quality and risk management programme is embedded. Corrective actions are implemented and evaluated where opportunities for improvements are identified.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. Ongoing education and training is in place, which includes in-service education and competency assessments.

Registered nursing cover is provided 24 hours a day, seven days a week. Residents and families reported that staffing levels are adequate to meet the needs of the residents.

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.		Standards applicable to this service fully attained.
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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. Fixtures, 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. The majority of staff hold a current first aid certificate.

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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Staff receive training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. The restraint coordinator maintains a register. During the audit, three residents were using restraints and five residents were using enablers. Staff regularly receive education and training in restraint minimisation and managing challenging behaviours.

Infection prevention and control

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

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	48	0	1	0	0	0
Criteria	1	99	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 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Birchleigh policies and procedures are being implemented that align with the requirements of the Code of Health and Disability Services Consumers' Rights (the Code). Families and residents are provided with information on admission, which includes information about the Code. Staff receive training about resident rights at orientation and as part of the annual in-service programme. Interviews with care staff (seven caregivers, three registered nurses, one diversional therapist and two activity assistants) confirmed their understanding of the Code. Six residents (three rest home level and three hospital level) and nine relatives (one hospital level, four dementia and four rest home) interviewed, confirmed that staff respect privacy, and support residents in making choices.</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</p>	FA	<p>Informed consent, advanced directives and medical care guidance instructions were recorded, as evidenced in nine resident files reviewed (three dementia, three rest home and three hospital). Residents in the dementia unit have an activated enduring power of attorney in place (EPOA). There was evidence that relative involvement occurs with the consent of the resident. Relatives/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. All nine resident files sampled had a signed admission agreement.</p>

give informed consent.		
<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>	FA	<p>Residents interviewed confirmed they are aware of their right to access independent advocacy services. Discussions with relatives confirmed the service provided opportunities for the family/EPOA to be involved in decisions. The resident files include information on residents' family/whānau and chosen social networks.</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>	FA	<p>Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. The activities programme includes opportunities to attend events outside of the facility. Entertainers are regularly invited to perform at the facility. Residents are supported and encouraged to remain involved in the community.</p> <p>Relatives and friends are encouraged to be involved with the service and care.</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>	FA	<p>The service has a complaints policy that describes the management of the complaints process. Each of the three units have the complaints policy posted in a visible area with complaints forms and advocacy information nearby. Information about complaints is provided on admission. Interviews with all residents and relatives confirmed their understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints.</p> <p>A complaints' register includes written and verbal complaints, dates and actions taken. Complaints are being managed in a timely manner, meeting requirements determined by the Health and Disability Commissioner (HDC). There is evidence of lodged complaints being discussed in manager and staff meetings. Three low level complaints for 2018 have been documented as resolved with appropriate corrective actions implemented. There have been no complaints for 2019.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>There is an information pack given to prospective residents and families that includes information about the Code and the nationwide advocacy service. Also included in the pack are individual leaflets with welcome information from each unit. There is the opportunity to discuss aspects of the Code during the admission process. Residents and relatives interviewed confirmed that information had been provided to them around the Code. Large print posters of the Code and advocacy information are displayed throughout the facility. A manager discusses the information pack with residents/relatives on admission. Families and residents are</p>

		informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement.
<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 they 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 established cultural policies to help meet the cultural needs of its residents. There is a Māori health plan. There were no residents who identified as Māori on the day of audit. Registered nurses advised that cultural needs were addressed in care plans sampled.</p> <p>Cultural and spiritual practice is supported, and identified needs are incorporated into the care planning process and review as demonstrated in resident files sampled. Discussions with care staff confirmed that they are aware of the need to respond to cultural differences.</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>An initial care-planning meeting is carried out where the resident and/or whānau, as appropriate, are invited to be involved. Individual beliefs or values are discussed and incorporated into the care plan. Six monthly multi-disciplinary team meetings occur to assess if needs are being met. Family are invited to attend. Relatives reported that they feel they are consulted and kept informed and family involvement is encouraged. Residents interviewed confirmed that staff consider their values and beliefs.</p>

<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Staff job descriptions include responsibilities. The three-monthly staff meetings include discussions around professional boundaries and concerns as they arise. Management provided guidelines and examples of mentoring for specific situations. Interviews with the managers and care staff confirmed their awareness of professional boundaries.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>CI</p>	<p>Evidence-based practice is evident, promoting and encouraging good practice. Policies and procedures align with current accepted best practice. The content of policy and procedures are sufficiently detailed to allow effective implementation by staff. Registered nursing staff are available seven days a week, 24 hours a day. A house GP visits the facility one day a week and an after-hours service is provided. The general practitioner (GP) reviews residents identified as stable every three months, with more frequent visits for those residents whose condition is not deemed stable. The GP interviewed is satisfied with the level of care that is being provided.</p> <p>The service receives support from the district health board, which includes visits from the mental health team and nurse specialist's visits. Physiotherapy services are provided on site four hours per week. A dietitian is also available for consultations. There is a regular in-service education and training programme for staff. A podiatrist is on site every six weeks. The service has links with the local community and encourages residents to remain independent.</p> <p>The service has implemented a number of quality projects and exceeded the standard around changes to processes around end of life care.</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>There is an accident/incident reporting policy to guide staff in their responsibility around open disclosure. Staff are required to record family notification when documenting incidents. All 15 incidents reviewed met this requirement. Family members interviewed confirmed they are notified following a change of health status of their family member and all accidents and incidents.</p> <p>Residents are welcomed on entry to Birchleigh and were given time and explanation about services and procedures. Residents and family are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. There is an interpreter policy in place and contact details of interpreters were available. The service has policies and procedures available for access to interpreter services for residents (and their family) if required. Resident and/or family meetings occur in each of the three units.</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) is certified to provide rest home, hospital (geriatric and medical) and dementia level care for up to 83 residents. On the day of audit there were 78 residents including 33 rest home level care residents, 25 hospital level care (including one under an exceptional care contract) and 20 dementia level care residents. All residents were under the aged residential care contract. One double room in the hospital unit is occupied by a married couple.</p> <p>The strategic business plan describes the mission statement, values and goals of Birchleigh. The strategic plan is supported by the 2019 to 2020 quality risk management plan. The board of directors consists of three long serving members who provide support and resources as required. One board member (interviewed) reported access to communication with board members anytime. A member of the board is on site at the facility three to four days a week. The DHB requested an update on plans to provide a connection between the rest home and hospital wing. Plans have been drafted and are awaiting approval.</p> <p>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 separately by an experienced nurse manager, all of whom are registered nurses. The hospital nurse manager has been in the role for eight years, the rest home nurse manager for 19 years, and the dementia nurse manager for two months. The dementia manager has been involved in aged care for many years and has experience in other management roles. Each of the nurse managers and the chief executive officer (CEO) have maintained at least eight hours of professional development activities related to managing an aged care facility.</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>	<p>FA</p>	<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</p>	<p>FA</p>	<p>An established quality and risk management system is embedded into practice. Quality and risk performance is discussed at three monthly unit meetings and monthly at the quality and senior management team meetings. The CEO provides a comprehensive report and meets with the board monthly. Discussions with</p>

<p>established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>the managers reflected staff involvement in quality and risk management processes.</p> <p>Resident meetings in the hospital and rest home are held one to two monthly. A family representatives meeting is held in the dementia unit three monthly. Minutes are maintained. Annual resident and relative surveys are completed with results communicated to residents and staff. Survey results last completed in November 2018 reflect high levels of satisfaction in all areas.</p> <p>Birchleigh has policies and procedures, and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are reviewed two yearly with input from clinical managers and external expertise as required. Clinical guidelines are in place to assist care staff. Updates to policies are communicated to staff as they occur.</p> <p>The quality-monitoring programme is designed to monitor contractual and standards compliance, and the quality of service delivery in each unit and across the facility. There are clear guidelines and templates for reporting including internal audits, hazard management, risk management, incident and accident, infection control data collection and complaints management. The facility has implemented established processes to collect, analyse and evaluate data, which is utilised for service improvements. Results are communicated to staff across a variety of meetings (including unit specific) and reflected actions being implemented and signed off when completed. A 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>Health and safety policies are implemented and monitored by the health and safety committee. The health and safety representative interviewed confirmed her understanding of health and safety processes including law changes from 2016. Two health and safety representatives have completed the external health and safety training. A current risk management plan, hazard control and emergency policies and procedures are in place. Hazards are identified, managed and documented on the hazard register. Action plans were implemented to address issues raised. There are procedures to guide staff in managing clinical and non-clinical emergencies. Birchleigh documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the board and staff so that improvements are made. Work safe recently reviewed Birchleigh's processes for worker engagement, participation and representation. The review identified there are good processes and training in place. Staff culture includes an understanding that health and safety is everyone's responsibility.</p> <p>Falls prevention strategies are in place including intentional rounding, sensor mats, post falls reviews and individual interventions.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p>	<p>FA</p>	<p>There is an incident/accident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring, corrective action to minimise and debriefing. Accidents and incidents</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>are analysed monthly with results discussed at monthly quality meetings and three-monthly staff meetings. Individual incident/accident reports are completed for each incident/accident with immediate action noted and any follow-up action required.</p> <p>A review of 15 incident/accident forms from April 2019 identified that forms were fully completed and include follow-up by a registered nurse. Neurological observations are carried out two-hourly for any suspected injury to the head. The nurse manager is involved in the adverse event process.</p> <p>The nurse managers were able to identify situations that would be reported to statutory authorities including (but not limited to) infectious diseases, serious accidents and unexpected death. Two outbreaks have been reported since the last audit.</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>Human resources policies include recruitment, selection, orientation and staff training and development. Fourteen staff files reviewed (three nurse managers, two registered nurses, six caregivers, a kitchenhand, one diversional therapist and one activities assistant) included a comprehensive recruitment process which included reference checking, signed employment contracts and job descriptions, police checks for recent starts, completed orientation programmes and annual performance appraisals. Staff turnover is very low and reflects a positive workplace.</p> <p>A register of registered nursing staff and other health practitioner practising certificates is maintained.</p> <p>The orientation programme provides new staff with relevant information for safe work practice. There is an implemented annual education and training plan that exceeds eight hours annually. The nurse managers in each area hold overall responsibility for staff education. There is an attendance register for each training session and an individual staff member record of training.</p> <p>The service has been proactive in working with staff to provide a supportive workplace. Birchleigh ran a series of workshops on empowering positive working relationships where staff contributed to the development of a set of values for the organisation to live by. With the support of the board, the values have been embedded into the ethos of the organisation providing a basis for employment related policies and procedures, employment contracts, and performance reviews. Management, with the support of the board, have provided access to an employee assistance programme for staff counselling on both work and non-work-related issues. In conjunction with this initiative, a staff survey identified potential concerns with staff relationships and workload. As a result of the feedback, management arranged for an external consultant to work through the issues. Positive changes were made to the way work was allocated. A work safe review supported Birchleigh's commitment to staff wellbeing. While it is too early to identify the value of this initiative, it is expected to deliver positive outcomes for staff and residents.</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>A policy is in place for determining staffing levels and skills mix for safe service delivery. Rosters implement the staffing rationale. There is a minimum of one RN on site at any time. Activities are provided seven days a week. The nurse managers each work 40 hours a week and provide on call.</p> <p>Silverstream, the rest home unit, has 32 residents. In addition to the nurse manager, an RN is rostered three mornings a week. They are supported by five caregivers (one long and four short). One of the short shifts works in a float position and is available to assist in the dementia unit. A kitchen shift also assists with breakfast and morning tea from 8.30 am to 11.30 am. There are three caregivers (one long and two short) on afternoon shift and one caregiver on night shift with a second float position shared between the rest home and dementia unit.</p> <p>Janefield the dementia unit has 20 residents. The nurse manager works the day shift and is supported by five caregivers (two long and three short). A kitchenhand works from 9.00 am to 1.00 pm and assists with morning tea and lunch. There are three caregivers on afternoon shift (two long and one short) and one caregiver plus the float from the rest home on night shift.</p> <p>Braeside the hospital unit has 25 hospital residents and one rest home resident on the day of audit. In addition to the nurse manager, an RN is rostered on each shift. They are supported by four caregivers (three long and two short). One of the short shifts works in a float position. A kitchen shift also assists with breakfast and morning tea from 7.30 am to 1.30 pm. There are four caregivers (two long and two short) on afternoon shift and one caregiver on night shift.</p> <p>Staff working on the days of the audit, were visible and attending to call bells in a timely manner as confirmed by all residents interviewed. Staff interviewed stated that overall the staffing levels are satisfactory and that the managers provide good support. Residents and family members interviewed reported there are sufficient staff numbers.</p>
<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>	<p>FA</p>	<p>The resident files were appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access. Entries are legible, dated and signed by the relevant caregiver or nurse, including designation. Individual resident files demonstrated service integration.</p>
<p>Standard 1.3.1: Entry To</p>	<p>FA</p>	<p>The service has admission policies and processes in place. Residents and relatives receive an information pack outlining services able to be provided, the admission process and entry to the service. The nurse</p>

<p>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>		<p>managers of each unit screen all potential residents prior to entry and record all admission enquiries. All residents are assessed by the need's assessment team prior to admission.</p> <p>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>The RNs interviewed described the nursing requirements as per the policy for discharge and transfers. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB using the yellow envelope system. 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 requirements and safe practice guidelines.</p>	FA	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. The service uses individualised blister packs for regular and or 'as required' (PRN) medications. Medication reconciliation is completed by two RNs on delivery of medication and any errors are fed back to pharmacy. All medications were securely and appropriately stored on day of audit. There are weekly controlled drug checks in all units.</p> <p>All staff who administer medication have been assessed for competency on an annual basis. Education around safe medication administration has been provided. RNs have completed syringe driver training.</p> <p>Eighteen medication charts were reviewed (six rest home, six hospital, and six dementia). The service uses an electronic medication management system. All charts reviewed had indications for use for all PRN medications. The medication charts reviewed identified that the GP had seen and reviewed the resident three-monthly.</p> <p>The GP and RN/unit manager in the dementia unit regularly review polypharmacy and the use of antipsychotic medication and reduction has occurred.</p> <p>Staff were observed to be safely administering medications. Registered nurses and caregivers interviewed could describe their role in regard to medicine administration. Standing orders are not used. There were no self-medicating residents at the time of audit.</p> <p>The medication fridge temperatures are recorded weekly and these are within acceptable ranges.</p>

		There is a signed agreement with the pharmacy.
<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>	FA	<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 and include photographs of how meals are to be presented. 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 RNs. Kitchen staff have completed food safety training. The cooks follow a rotating menu, which has been reviewed by a dietitian. A food control plan is in place expiring on 30 April 2020. 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>	FA	<p>The service records the reason for declining service entry to prospective residents should this occur and communicates this decision to prospective 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>	FA	<p>All nine resident files sampled contained long-term interRAI assessments. Files sampled evidenced appropriate and timely re-assessment of interRAI assessments. The interRAI outcomes were reflected in the long-term care plans. Risk assessments were completed at least six monthly. Behaviour assessments and management plans were included in the files reviewed of residents in the dementia unit.</p>

<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>The long-term care plans reviewed reflected the outcomes of a range of assessment tools. Interventions to support pressure injury (PI) prevention was documented for one resident with a grade 2 pressure injury, and residents at risk of developing pressure injuries. Comprehensive end of life interventions were in place for the resident on exceptional circumstances contract. InterRAI assessment caps and triggers were well linked and highlighted throughout the care plan. There was documented evidence of resident/relative/whānau involvement in the care planning process.</p> <p>Short-term care plans are available for use to document any changes in health needs with interventions, management and evaluations. Short-term care plans reviewed had been evaluated at regular intervals.</p> <p>Medical GP notes and allied health professional progress notes are evident in the resident's integrated notes and on the electronic medicine charting system.</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>When a resident's condition alters, the RN initiates a review and if required a GP visit. Communication to the GP for a residents' change in health status were sighted in the resident's files. Residents interviewed reported their needs were being met. Relatives interviewed stated their relative's needs were being appropriately met.</p> <p>Wound assessments, treatment and evaluations were in place for all current wounds. There were two hospital residents with a facility acquired pressure injury (both superficial stage 2). There were no wounds in the dementia unit, two wounds in the rest home unit (one chronic wound, and one skin tear), and four wounds in the hospital unit (two skin tears, one leaking lower leg due to oedema, and one cancerous lump). GPs are notified of all wounds. Adequate dressing supplies were sighted in the treatment rooms. Staff receive regular education on wound management.</p> <p>Continence products are available and resident files include urinary continence assessment, bowel management and continence products identified for day use, night use and other management. Specialist continence advice is available as needed and this could be described by the RNs interviewed.</p> <p>Monitoring forms in place include (but are not limited to): monthly weight, blood pressure and pulse, food and fluid charts, and behaviour charts, repositioning is recorded in the progress notes, and blood sugars and pain are recorded in the medication charts in the electronic system.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity</p>	<p>FA</p>	<p>The service employs one diversional therapist who works 35 hours a week and is based in the rest home. She is supported by three activities coordinators. Each resident has an assessment completed soon after admission, the activities care plan is developed using the information from the assessment. All activities plans have been evaluated six monthly, attendance records are maintained, and monthly reports were documented in each residents file. Each unit has a separate activity planner reflective of residents cognitive and physical</p>

<p>requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>abilities. The activities programme is displayed on noticeboards around the facility, and in each resident room. There are combined activities held in-house, and with another facility. There are volunteers who visit the facility and assist with the activities programme. Birchleigh own two vans; one can accommodate wheelchairs. Van outings are provided weekly for each unit. All activities staff have current first aid certificates. There are three monthly resident and relatives' meetings, which provide an opportunity for feedback and suggestions for the programmes. Residents and relatives were complementary of the activities programme, and stated the programmes are varied.</p> <p>Activities in the dementia unit are provided over six days a week each morning and afternoon. There is a variety of group and individual activities such as balloon games, craft, baking and table tennis. Individual activities include going for walks, creating memory boxes and hand massages. Activities resources are available for staff to access. There were 24-hour activity care plans documented in the three dementia resident files sampled. Relatives and staff interviewed in the dementia unit, advised that the residents are frequently taken on walks outside and van outings weekly. Music and pet therapy is offered.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>All initial care plans are evaluated by the registered nurses within three weeks of admission. Long-term care plans reviewed had been evaluated by RNs six-monthly, or when changes to care occurred. Written evaluations describe the residents progress against the residents (as appropriate) identified goals. Short-term care plans were evaluated and either resolved or added to the long-term care plan as an ongoing problem. Relatives are invited to attend the three-monthly reviews held with the GP and are notified of the outcome of the review if unable to attend. Relatives interviewed confirmed they are invited to attend the care plan reviews and GP visits.</p>
<p>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.</p>	<p>FA</p>	<p>The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. Examples of referrals sighted were to the needs assessment coordination service, palliative nurse specialist, physiotherapist, mental health support of the older persons (DHB), lymphedema (DHB).</p> <p>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 relatives as evidenced in interviews and medical notes. The staff provided examples of where a resident's condition had changed, and the resident was reassessed.</p>

<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>All chemicals are labelled with manufacturer labels. There are designated areas for storage of cleaning/laundry chemicals and chemicals were stored securely. Laundry and sluice rooms are locked when not in use, as observed during a tour of the facility. Material safety datasheets were available, and the hazard register identifies hazardous substances. Gloves, aprons, and goggles are available for staff. Safe chemical handling training has been provided.</p> <p>All chemicals are labelled with manufacturer labels. There are designated areas for storage of cleaning/laundry chemicals and chemicals were stored securely. Laundry and sluice rooms are locked when not in use, as observed during a tour of the facility. Material safety datasheets were available, and the hazard register identifies hazardous substances. Gloves, aprons, and goggles are available for staff. Safe chemical handling training has been provided.</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>	<p>FA</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 2020.</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 person maintains a documented preventative and reactive maintenance schedule. Water temperatures are monitored and within range.</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 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>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided</p>	<p>FA</p>	<p>All bedrooms have access to hand basins. There are adequate numbers of communal toilets and shower rooms. There are communal toilets located close to communal areas in the rest home, dementia and hospital areas. 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 reported their privacy is</p>

with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.		maintained at all times.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	There is adequate space in the bedrooms and enough space for the safe manoeuvring of mobility equipment. Residents can personalise their rooms.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	<p>The rest home area has a separate dining area which is set out to encourage social interaction at mealtimes. The lounge area is 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.</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 lounge and dining areas can be observed from the nurses' station.</p>
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided	FA	There are cleaning and laundry policies and procedures in place. 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. Each unit has a small laundry for residents'

<p>with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>		<p>delicate and woollen personal clothing. There are defined clean/dirty areas in all of the laundry areas. There were adequate linen supplies sighted in the facility linen-store cupboards. Internal audits monitor the effectiveness of laundry and cleaning processes. Cleaners' trolleys are stored in locked areas when not in use.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>There are emergency and disaster manuals to guide staff in managing emergencies and disasters. There is a minimum of one first aid trained staff member on every shift and during outings. The facility has an approved fire evacuation plan. Fire drills take place every six months. The facility has back up lighting, power and sufficient food, water and personal supplies to provide for its maximum number of residents in the event of a power outage. There is a gas barbeque and spare gas bottles. Electronic call bells were evident in resident's rooms, lounge areas, and toilets/bathrooms. There are emergency generators that can provide power to critical services. These are tested monthly.</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, panel heaters and under floor heating. The temperature is thermostat controlled and can be individually adjusted in the resident bedrooms. Residents and relatives 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>	FA	<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 good 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 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>	FA	<p>There are infection control policies and procedures appropriate for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies were developed by previous IC nurses 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>	FA	<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>	FA	<p>Infection surveillance is an integral part of the infection control programme and is described in the Birchleigh</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>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 two outbreaks, both of which were reported and appropriately managed.</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>Restraint practices are only used where it is clinically indicated and justified, and other de-escalation strategies have been ineffective. Restraint minimisation policies and procedures are comprehensive, and include definitions, processes and use of restraints and enablers.</p> <p>There were five residents using enablers (all hospital) and three residents using intermittent restraints during the audit (two hospital and one dementia).</p> <p>Two resident files were reviewed where an enabler was in use. Voluntary consent and an assessment process were completed. The enabler is linked to the resident's care plan and is regularly reviewed. Three resident files where restraint was in use were reviewed. All required documentation was completed including assessments, consents and monitoring.</p> <p>Staff training is in place around restraint minimisation and enablers, falls prevention and analysis and management of challenging behaviours.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	<p>FA</p>	<p>The restraint approval process is described in the restraint minimisation policy. Roles and responsibilities of the restraint coordinator (a registered nurse) and for staff are documented and understood. The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements.</p>

<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>A restraint assessment tool is completed for residents requiring an approved restraint for safety. Assessments are undertaken by the restraint coordinator in partnership with the RNs, GP, resident and their family/whānau. Restraint assessments are based on information in the care plan, resident/family discussions and observations.</p> <p>Ongoing consultation with the resident and family/whānau are evident. Three hospital level residents' files where restraint was in use (lap belts) were selected for review. The completed assessment considered those listed in 2.2.2.1 (a) - (h).</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>Procedures around monitoring and observation of restraint use are documented in policy. Approved restraints are documented. The restraint coordinator (hospital nurse manager) is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialed before implementing restraint.</p> <p>The use of restraint is linked to the residents' care plans. Internal restraint audits measure staff compliance in following restraint procedures. Each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. Monitoring is documented on a specific restraint monitoring form, evidenced in two resident files where restraint was being used.</p> <p>A restraint register is in place providing an auditable record of restraint use and is completed for all residents requiring restraints and enablers.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>Restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations are conducted monthly, and restraint use is discussed at restraint committee meetings three times a year and at clinical, staff, quality and management team meetings. A review of three resident files identified that evaluations are up to date.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>The restraint minimisation programme is discussed and reviewed at the four-monthly facility-wide restraint meetings, monthly clinical meetings and monthly staff/quality meetings. Meeting minutes include (but are not limited to) a review of the residents using restraints or enablers, updates (if any) to the restraint programme and staff education and training.</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 1.3.3.4</p> <p>The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.</p>	PA Low	<p>Progress notes are maintained by caregivers at the end of each shift. Registered nurses document in the notes if there are concerns, changes in medications, following GP visits, and when an incident or infection has occurred, however there were not always regular reviews by a registered nurse documented consistently. There are separate GP notes, the dietitian documents in the GP notes, there is separate physiotherapist and podiatrist notes.</p>	<p>Two dementia files and two rest home files had no entries by the RNs for periods up to two months showing no evidence of RN input to care.</p>	<p>Ensure registered nurses document progress notes regularly to evidence assessment.</p> <p>60 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 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>As a result of personal experience and the opportunity to fully utilise Hospice services, Birchleigh identified an opportunity to improve the ability of staff to safely and sensitively deal with residents and families in the last</p>	<p>At the beginning of 2018, Birchleigh established a quality goal of improving the level of palliative care skills and knowledge of staff and improving the end days for residents and their families. Education was provided through the Otago Community Hospice and included, (but was not limited to) management of pain, nausea and vomiting, dementia and delirium, skin management and physical comfort. Staff also discussed communication advanced directives and involving the residents and their specific wishes and the dying process. The training sessions (role specific) were attended by 95% of staff. As a result, staff are able to readily recognise the varying stages of the dying process and reassure residents and families. The service developed and published two leaflets for residents and families. The first on understanding the dying process explains the physical changes and what can be done to help with each change. The second for families and friends provides information on what happens when a loved one passes away, focusing on the time between and the resident leaving Birchleigh. Both pamphlets are written in an easy to read and understand manner.</p> <p>Many of the outcomes from this initiative are intangible, however on the day of audit the service provided several copies of correspondence from the families of residents who had died with specific reference to the support from all staff. All supporting correspondence sighted was 100% positive.</p>

		days of life.	
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End of the report.