

Birchleigh Management Limited - Birchleigh Residential Care Centre

Introduction

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

The audit has been conducted by BSI Group New Zealand Ltd, 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: 23 September 2021 End date: 24 September 2021
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:	83



Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

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

This unannounced surveillance audit was conducted against a sub-set of 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 an established quality and risk management system. Residents, families, and the general practitioner interviewed commented positively on the standard of care and services provided.

The one shortfall identified as part of the previous audit has been addressed around progress note documentation.

This audit has identified one area requiring improvement around the staff orientation programme.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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The service has a culture of open disclosure. Families are regularly updated including any acute changes or incidents. Complaints processes are implemented and managed in line with the Health and Disability Commissioner's Code of Health and Disability Consumers' Rights.

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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Services are planned, coordinated, and are appropriate to the needs of rest home, hospital, and dementia level residents. Goals are documented for the service with evidence of regular reviews. Quality and risk management programmes are embedded in practice. Corrective actions are implemented and evaluated where opportunities for improvements are identified.

Residents receive appropriate services from suitably qualified staff. Human resources are established in accordance with good employment practice. Ongoing education and training are 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.		Standards applicable to this service fully attained.
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Registered nurses are responsible for each stage of service provision. The registered nurses assesses and reviews residents' needs when health changes against, outcomes and goals. Resident files included: medical notes and notes of other visiting allied health professionals. Residents interviewed confirmed they were involved in the care planning and review process.

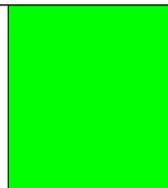
Each resident has access to an individual and group activities programme. The group programme is varied and includes outings and community involvement.

The service uses an electronic medication system. Staff who are responsible for the administration of medicines, complete annual education, and medication competencies. The general practitioner reviews medications three-monthly.

All meals are prepared by an external contractor. Individual and special dietary needs are catered, and alternative options are available for residents with dislikes. A dietitian has reviewed the menu. Residents interviewed responded that their likes and dislikes are catered for. There are additional snacks available.

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.

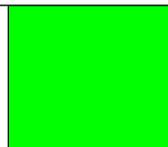


Standards applicable to this service fully attained.

Chemicals are stored safely throughout the facility. Appropriate policies are available along with product safety charts. Fire checks are conducted six-monthly by an external provider in line with the facility's building warrant of fitness.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.



Standards applicable to this service fully attained.

The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. The restraint coordinator/nurse manager maintains a register. Staff receive training around restraint minimisation and the management of challenging behaviours. During the audit, three residents were using restraints and one resident was using an enabler.

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.

There is a monthly surveillance programme, where infections are collated, analysed, and trended with previous data. Where trends are identified, actions are implemented to reduce infections. The infection surveillance results are reported at the staff meetings and management quality meetings. Evidence is seen of education and staff involvement with any infections that are identified during the surveillance programme. Covid-19 prevention strategies have been implemented.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	15	0	1	0	0	0
Criteria	0	40	0	1	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](#).

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service has a complaints policy that describes the management of the complaints process. Each of the three units (rest home, hospital, and dementia) 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 seven residents (three hospital, four rest home) and relatives confirmed their understanding of the complaints process. Interviews with five managers (chief executive officer, one service manager, three nurse managers) and fourteen staff (four healthcare assistants (two hospital, one rest home, one dementia), four RNs (three hospital one rest home), one kitchen hand, two contracted kitchen staff, three activities staff (one diversional therapist, two activities coordinators) confirmed their understanding of the complaints reporting process.</p> <p>A complaints' register includes written and verbal complaints, dates and actions taken. Complaints lodged since the previous audit were reviewed (one rest home, three dementia, no hospital). There was evidence of complaints being acknowledged, investigated, and resolved. Time frames meet the Health and Disability Commissioner's (HDC) guidelines for responding to a complaint.</p> <p>There is evidence of lodged complaints being linked to the quality and risk management system. Staff are kept informed.</p>
Standard 1.1.9:	FA	There is an accident/incident reporting policy to guide staff in their responsibility around open disclosure. Staff

<p>Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>are required to record family notification when documenting incidents. All 20 incidents reviewed met this requirement. Interviews with six relatives (two rest home, one hospital, three dementia) confirmed they are notified following a change of health status of their family member and/or any accident or incident.</p> <p>Residents are welcomed on entry to Birchleigh and are 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 are available. Family and staff are used in the first instance.</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, the facility was at full occupancy with 83 residents (34 rest home, 25 hospital and 24 dementia). There are no designated dual-purpose rooms although special approval has been granted by the DHB to place a married couple (one rest home and one hospital) in a double room with a dedicated ensuite in the hospital wing. Two residents (one rest home, one hospital) are funded by ACC. All remaining residents were under the age-related residential care contract (ARCC).</p> <p>The strategic business plan describes the mission statement, values, and goals of Birchleigh. The board of directors consists of three long serving members who provide support and resources as required. Annual business goals are regularly reviewed in the board and management meetings.</p> <p>The CEO has been in his role for over 14 years. Clinical oversight is provided by a service manager (the full title is Manager of Service Excellence, however for the purpose of this report the title is shortened to Service Manager) who has been in her role for one year. She is an RN with a current practising certificate and has worked in managerial roles in the aged care sector since 2008. Each of the three units (rest home, hospital, dementia) is managed separately by an experienced nurse manager/RN. The hospital nurse manager has been in the role for over ten years, the rest home nurse manager six months, and the dementia nurse manager for over two years.</p> <p>The managers maintain at least eight hours of professional development activities per annum relating to managing an aged care facility.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and</p>	<p>FA</p>	<p>The quality and risk management systems are transitioning to an online system. Quality and risk performance is discussed at the three-monthly unit meetings and monthly at the quality and management team meetings. Quality and risk activities are presented monthly to the Board. Discussions with the managers and staff confirmed their understanding and involvement in quality and risk management activities.</p> <p>Resident meetings in the hospital and rest home are scheduled three monthly with family meetings in the dementia unit taking place six-monthly. Minutes are maintained. Annual resident and relative surveys are</p>

<p>maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>completed with results communicated to residents and staff. Survey results last completed in February 2021 reflect high levels of satisfaction in all areas. No negative trends were identified.</p> <p>Policies and procedures have transitioned to an electronic management system, designed for aged residential care. Clinical guidelines are in place to assist care staff. Updates to policies are communicated to staff as they occur. 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 that cover internal audits, hazard management, risk management, incidents and accidents, 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.</p> <p>Health and safety policies are implemented and monitored by the health and safety committee. The health and safety officer interviewed (service manager) confirmed her understanding of health and safety processes. 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 are implemented to address issues raised. There are procedures to guide staff in managing clinical and non-clinical emergencies. 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. A physiotherapist is onsite two days (approximately four hours) per week.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>There 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 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 20 incident/accident forms across the three units and including witnessed and unwitnessed falls, behaviours that challenge, and medication errors, identified that the electronic forms were fully completed and include follow-up by a registered nurse. Neurological observations are carried out for any suspected injury to the head as per policy.</p> <p>The nurse managers were able to identify situations that were reported to statutory authorities since the previous audit including notification to public health authorities for one outbreak and the completion of Section 31 reports for two pressure injuries and the change of clinical manager.</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>PA Low</p>	<p>Human resources policies include recruitment, selection, orientation, and staff training and development. Seven staff files reviewed (one registered nurse, five healthcare assistants, one cleaner) included evidence of reference checking, signed employment contracts and job descriptions, police checks, and annual performance appraisals. Staff turnover is 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. Two of seven orientation checklists were missing in staff files (one cleaner, one healthcare assistant/rest home). The service manager reported that she is currently revising the orientation checklist for non-clinical staff (e.g., cleaners, laundry, kitchen hand) and has not retained documented evidence of their orientation.</p> <p>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. Seven of sixteen RNs have completed their interRAI training. Registered nurses have access to external education through the DHB and Hospice.</p> <p>At rest home level of care, there are 23 caregivers employed. Three have completed their level three Careerforce qualification (or its equivalent) and seven have completed their dementia qualification. At dementia level of care, in addition to the dementia qualification, three caregivers have completed a level three qualification and one has completed their level four. At hospital level of care 21 caregivers are employed. Ten have completed their level three qualification and three have completed their level four. Ten have completed their dementia qualification. Twenty-two healthcare assistants work in the dementia unit. Eighteen have completed the required dementia standards, one is in the process and completing theirs (employed for less than 18 months) and three have recently been employed and have not yet enrolled.</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 (rest home unit with 33 residents): In addition to the nurse manager, an RN is rostered five days a week (two long shifts and three short shifts). They are supported by five healthcare assistants (two long and three short). There are three healthcare assistants (one long and two short) rostered on the afternoon shift and one healthcare assistant rostered on the night shift with a second float position shared between the rest home and dementia units.</p> <p>Janefield (dementia unit with 24 resident): The nurse manager is supported by an additional RN two days a week. Four healthcare assistants cover the AM shift (one long and three short). Four healthcare assistants are rostered on the afternoon shift (two long and two short with additional support provided by an EN (1200 – 2030).</p>

		<p>One healthcare assistant is rostered on the night shift with a second float position shared between the rest home and dementia units.</p> <p>Braeside (hospital unit with 26 residents (25 hospital and one rest home)): In addition to the nurse manager, an RN is rostered on each shift. They are supported by five healthcare assistants (three long and two short). There are four healthcare assistants rostered on the afternoon shift (two long and two short) and one healthcare assistant 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 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication management policies and procedures comply with medication legislation and guidelines. All medications and medication trolleys are stored safely in the locked medication rooms. There are monthly checks of stock levels and expiry dates. Birchleigh uses an electronic medication management system. Medications are checked on arrival and discrepancies are feedback as errors to the pharmacy. Medication errors are documented on incident forms and discuss at quality meetings. Regular medication internal audits are completed, and corrective actions implemented and signed off.</p> <p>Registered nurses administer medications in the hospital, rest home and dementia unit and medication competent healthcare assistants assist with the process. All staff who administer medications completed annual medication competencies. Policies and procedures support practice and training has been provided. Self-administration of eyedrops by residents (two in the hospital) is managed as per guidelines and policy. The GP interviewed advised that three monthly medication reviews are completed and minimal attitude to anti-psychotic medication is adhered to. Staff were observed safely administering medications on the days of audit. There are approved guidelines for a list of nurse-initiated medication.</p> <p>Twelve electronic medication files were reviewed. All files reviewed evidenced the resident's photograph, allergy status and correct prescribing.</p> <p>'As required' medication was appropriately prescribed and administered, and effectiveness noted in either the comments section of the progress notes or the electronic resident management system or one the electronic management system itself. Enteral feeds where prescribed is on the electronic medication management system.</p> <p>Storage of medications were correctly managed and recording of medication room and medication fridge temperatures were electronically monitored with software, the general manager will inform the nurse managers when temperatures were outside the normal parameters and corrective actions needed. Medication were within expiration and eye drops and ointments were dated.</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 is provided by an external food service contractor. All meals and snacks are prepared in a large well-equipped kitchen at the retirement village adjacent to the care facility.</p> <p>The food services manager is a qualified chef and was able to discuss the food service transportation to Birchleigh. The director for the contracted company was present on the day of the audit. The food services manager was knowledgeable regarding the current menu and all aspects of the food service. The food services manager is supported daily by a second weekend kitchen manager and a kitchen hand. The roster is adequate for the size of the facility.</p> <p>The menus are reviewed by the company dietitian and last reviewed in April 2021. There are food service meetings within the external catering service, and they get feedback from resident meetings /surveys. Food service staff are trained in food safety. The chiller and freezer temperatures are recorded daily, and food temperatures are recorded at each mealtime. All temperatures are recorded on an electronic food service management system.</p> <p>The meals are transported in hot boxes to the three servery, one servery located in each unit. Meals are plated and serve directly from the bain-marie and plated and served by a kitchen hand. Plates are name labelled where special dietary requirements are known and where residents have their meals in their rooms. The food services manager or kitchen manager receives a nutritional assessment for each new resident and is notified of any changes, special diets, dietician instructions for weight loss.</p> <p>Cultural, religious and food allergies are accommodated. Special diets accommodated are gluten free, dairy free, modified diets such as soft, mince and moist and pureed. The food services manager interviewed could identify residents with special nutrition needs like swallowing difficulties and weight loss. The lunch meal was observed in the rest home and in the dementia unit, enough healthcare assistants were available in the dining room to assist residents with their meals. Additional food and snacks are available and accessible any time of the day.</p> <p>Residents and family members interviewed expressed satisfaction with the meals and individual likes, dislikes and preferences are catered for. Food profiles, dietary needs and allergies are recorded. Weight monitoring occurs and the dietitian are involved with any residents who are experiencing weight loss. A food first approach to weight loss is implemented. Supplements and fortified meals are provided to those residents requiring these. Special equipment including utensils was observed to be in use. A food control plan is in place and local council verification has occurred with a current annual certificate displayed. The food control plan is current and expires April 2022.</p> <p>The chemical provider completes a monthly check on the dishwasher function and temperatures. A cleaning schedule is maintained. The dry goods store has all goods sealed and labelled. The kitchen staff were observed wearing appropriate personal protective clothing. Feedback is received from meetings, family</p>

		<p>members and through annual surveys. Residents and relatives interviewed are satisfied with the food service, choices, and option available.</p> <p>Nutritious snacks and fruit platters are available 24 hours a day. There is a supply of snacks (including a nibble platter) in the dementia unit servery area.</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 changes the RN initiates a GP or nurse specialist consultation. Short- term care plans are completed for changes to care/supports required and communicated at handovers. Registered nurses (RNs) and healthcare assistants (HCAs), follow the care plan and report in progress notes against the care plan each shift. When a resident's condition alters, the registered nurse initiates a GP review if required. The community mental health maintains a close liaison with the RNs and, GP. There is evidence in the progress notes of the nurse manager communication with the psychogeriatric nurse practitioner. The relatives interviewed stated their expectations were being met and they were notified of any changes to health, incidents, infections, GP visits and medication changes.</p> <p>Residents with swallowing difficulties had been reviewed by a GP, dietitian, speech, and language therapist and referred to radiology for further tests. Healthcare assistants in the hospital were observed to adhere to the organisations ` two person assist transfer policy when hoisting and repositioning residents. Observation on the day also included healthcare assistants' communication to be appropriate and effective with residents with hearing difficulties.</p> <p>Staff have access to sufficient medical and clinical supplies available such as equipment and dressings. All wounds have wound assessments, pain scores, photos, sizes, dressing plan and evaluations completed on the due dates. There was a total of 18 current wounds treated across the service (eleven across the hospital unit including two chronic wounds, three skin tears in the dementia unit and four in the rest home including two chronic wounds. There has been wound specialist input for two of the wounds in the hospital and two in the rest home. There were no pressure injuries treated on the day of the audit.</p> <p>Wound management policies and procedures are in place. Wound assessments, evaluation and monitoring documentation were completed within required timeframes for each of wound. Pressure relieving devices in place included roho cushion, pressure relieving mattresses, heel protectors and two hourly repositioning charts. There is evidence that previous recorded stage 1 and stage 2 pressure injuries has resolved in a timely manner with RN input only. Associated pain charts were completed where analgesia was administered.</p> <p>Sufficient continence products are available and resident files include a continence assessment and plan as part of the care plan. Specialist continence advice is available as needed and this could be described.</p> <p>There are twenty-four-hour diversional therapy plans on the files for those residents in the dementia unit and describe the resident's usual signs of wellness, changes and triggers, interventions, and de-escalation techniques (including activities), for the management of challenging behaviours. The monitoring charts were</p>

		<p>maintained as required including behaviour monitoring charts used in the dementia unit for residents with challenging behaviours or new behaviours.</p> <p>Monitoring forms include pain, observations, neurological observations, 24-hour fluid intake, blood sugar levels, weight, re-positioning charts, food and fluid, resident hygiene and bowel charts, challenging behaviour, restraint monitoring and toileting charts. All monitoring forms are completed on the electronic management system or uploaded to the system when paper based</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>	<p>FA</p>	<p>Activities provided are appropriate to the needs, age, and culture of the residents. The activities are physically and mentally stimulating. There is one qualified diversional therapist (DT) supported by four activities coordinators. The DT is working Monday to Fridays 35 hours in the rest home and a Saturdays 9am-1pm is covered by a part time employee. Activities coordinators in the hospital (30 hours per week) and dementia unit (10am-4.30pm) works Monday to Fridays. There is an afternoon activities person for the dementia unit (1 pm-4.30pm on a Saturday). There is a volunteer in the hospital on Tuesdays and Wednesdays to assist with activities in the hospital unit only.</p> <p>All had training for their roles and develop the weekly activity plans with the residents. There is a separate activity programme for each unit (one hospital, one dementia and one for the rest home) that meets the individual physical, cognitive, intellectual, and spiritual/cultural preferences of the residents. Small group activities and one-on-one time with residents were included in the programmes. Activities staff advised that residents have input into the activities programme and links to the community are a focus of the programme.</p> <p>On the day of the audit a few residents participated in news reading. Van outings/scenic drives are weekly and there are two activity staff on each outing. One van has wheelchair access. All activity staff have a current first aid certificate.</p> <p>Activities varied according to the residents` interest and include van drives, devotion, animal therapy, music entertainers, gardening, exercises, and wheelchair walks. The hairdresser visits Tuesdays to Fridays. There is a salon on site.</p> <p>The weekly activities are posted in each unit on the noticeboards and in the residents` rooms. Healthcare assistants provide support with activities during the weekend. There are sufficient activity resources available. The activity plans sampled were well-documented and reflected the resident's preferred activities and interests. The resident's activities participation log was sighted. The DT and activities coordinators confirmed that the programme is flexible and can change, their focus is on resident input into the activity's planner.</p> <p>This audit was conducted during Covid- 19 level 2 guidelines and there were no combined activities between the units. Activities are planned over seven days with assistance from HCAs to initiate activities.</p> <p>Staff were observed interacting with residents in the dementia unit using diversion strategies for residents who</p>

		<p>required this. In the hospital unit the activities coordinator was observing doing one on one hand massage therapy with one resident.</p> <p>Residents and families interviewed verbalised the activities provided by the service are adequate and enjoyable. A 24-hour activity plan is in place for all residents in the dementia unit and reflected de-escalating techniques when behaviour becomes challenging. Individual activity plans were reviewed six monthly in files sampled.</p> <p>Feedback on the programme is received through six weekly resident meetings in each unit and relative gatherings. Relatives interviewed confirmed their satisfaction around activities offered and confirmed they are kept up to date.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Files reviewed (for all long-term residents) demonstrated that the long-term care plans were evaluated at least six monthly (or earlier if there was a change in health status). Changes in health status were documented and followed up. Short-term care plans sighted were evaluated and resolved or added to the long-term care plan if the problem was ongoing, as sighted in resident files reviewed. Three monthly clinical review meetings were held with the EPOA/relatives and the resident, interventions records where progress is different from the expected goal. Changes are updated on the long-term care plan. The GP reviewed the resident at least three monthly. Other allied health professionals involved in the care of the resident provide input at the six-monthly care plan.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>There are established systems in place to ensure the physical environment and facilities are safe and fit for their purpose. The facility has a building warrant of fitness, issued by the Dunedin City Council. Expiry certificates are behind schedule due to Covid lockdowns, confirmed in a letter from the Dunedin City Council. Evidence was sighted of six-monthly fire safety checks by an external provider. Fire evacuation drills take place every six months.</p> <p>Maintenance is undertaken by both internal maintenance personnel and external contractors. Electrical safety test tag system shows this has occurred (August 2021). 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 healthcare assistants and RNs interviewed stated that they have the equipment referred to in care plans</p>

		<p>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 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place, appropriate to the complexity of service provided. The nurse managers for each unit collates monthly data for their units for all infections based on signs and symptoms of infection. Surveillance of all infections for each unit is entered separately into a monthly infection summary register. The infection control coordinator collates and combines all data on the electronic system to identify trends. Surveillance results are reported to the facility meetings and minutes are made available to read. Trending and analysis of infections is undertaken monthly and annually. The data has been monitored and evaluated at organisational level. The IPC nurse (dementia unit nurse manager) interviewed confirm that decreasing the number of urine tract infections were identified as a quality focus.</p> <p>Covid-19 prevention strategies have been implemented within the facility. There are robust processes documented and include a full monthly stocktake of personal protective equipment and recorded cleaning processes for equipment and protective eyewear. Staff were observed practicing good hand washing techniques. There are plenty of gloves available in the hallways (not resident rooms). Staff completed hand hygiene as part of IPC education and recently completed competencies. Staff were observed in the hospital wing to practice good hygiene.</p> <p>There has been one gastro related outbreak in August 2020 since the previous audit. All affected residents were contained to one unit, reported to Public Health, of short duration and managed appropriately.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<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 was one hospital level resident voluntarily using bedrails as an enabler and three residents using t-belts intermittently as a restraint (two dementia, one hospital).</p> <p>The resident file for the enabler file was reviewed. Voluntary consent and an assessment process were completed. The enabler is linked to the resident's care plan and is regularly reviewed.</p> <p>Staff training is in place around restraint minimisation and enablers, falls prevention and analysis and management of challenging behaviours.</p>

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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 1.2.7.4</p> <p>New service providers receive an orientation/induction programme that covers the essential components of the service provided.</p>	PA Low	All staff undergo an orientation programme. Documented evidence of this occurring was missing in a sample of staff files reviewed and confirmed during an interview with the service manager.	Two of seven orientation checklists were missing from staff files reviewed.	<p>Ensure each staff file contains documented evidence of staff completing an orientation programme.</p> <p>90 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.