# 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 Ngā paerewa Health and disability services standard (NZS8134:2021).

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 Manatū Hauora (the Ministry of Health).

The abbreviations used in this report are the same as those specified in section 0.4 of the Ngā paerewa Health and disability services standard (NZS8134:2021).

You can view a full copy of the standard on the Manatū Hauora website by clicking here.

The specifics of this audit included:

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| **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: 7 November 2024 End date: 8 November 2024 |

**Proposed changes to current services (if any):** The service applied for a reconfiguration of a previous double hospital room to a dual purpose (rest home/ hospital) double room to accommodate a married couple (letter dated 9 August 2023). This room was verified as suitable for two residents to share. The total number of beds remains unchanged.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 80

# 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 sections contained within the Ngā paerewa Health and disability services standard:

- ō tātou motika │ our rights
- hunga mahi me te hanganga │ workforce and structure
- ngā huarahi ki te oranga │ pathways to wellbeing
- te aro ki te tangata me te taiao haumaru │ person-centred and safe environment
- te kaupare pokenga me te kaitiakitanga patu huakita │ infection prevention and antimicrobial stewardship
- here taratahi │ restraint and seclusion.

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

**Key to the indicators**

| Indicator | Description | Definition |
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| | Includes commendable elements above the required levels of performance | All subsections applicable to this service fully attained with some subsections exceeded |
| | No short falls | Subsections 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 subsections applicable to this service partially attained and of low risk |

| Indicator | Description | Definition |
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| | A number of shortfalls that require specific action to address | Some subsections 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 subsections applicable to this service unattained and of moderate or high risk |

## General overview of the audit

Birchleigh Residential Care Centre provides rest home, hospital, and dementia level care for up to 84 residents, including a double room which was occupied on the day of the audit. On the day of the audit, there were 80 residents.

The service is managed by the Chief Executive Officer and a senior management team. There is a board which monitors service delivery and provides advice and support to the Chief Executive Officer. The service continues to implement environmental upgrades. The residents and families/whānau interviewed spoke positively about the care and support provided. Resident and families/whānau satisfaction survey results shows satisfaction with the services provided.

This surveillance audit was conducted against a sub-section of Ngā Paerewa Health and Disability Services Standard 2021 and funding agreements with Health New Zealand Te Whatu Ora. The audit processes included observations, a review of organisational documents and records, including staff records and the files of residents, interviews with residents and families/whānau, and interviews with staff, management, and the general practitioner.

The service has addressed two of the previous five shortfalls regarding communication and staff competencies. The remaining three shortfalls regarding care plan interventions, monitoring charts and aspects of medication management remain ongoing.

This surveillance audit identified shortfalls around internal audits, essential notifications, care plan timeframes and evaluations.

## Ō tātou motika | Our rights

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| Includes 10 subsections that support an outcome where people receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of people's rights, facilitates informed choice, minimises harm, and upholds cultural and individual values and beliefs. | | Subsections applicable to this service are fully attained. |

Birchleigh Residential Care Centre has a Māori health plan and a Pacific health plan and other relevant documents to fulfil their obligations and responsibilities under Te Tiriti o Waitangi. Individualised care is delivered with a specific emphasis on acknowledging and respecting the beliefs, values, and cultural backgrounds of each person.

It was evidenced the Health and Disability Commissioner's Code of Health and Disability Services Consumers Rights has been effectively implemented. Observations and evaluations during the audit underscore a commitment to upholding the rights and dignity of all residents. Informed consent processes are implemented. The complaints management process is implemented.

## Hunga mahi me te hanganga | Workforce and structure

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| Includes five subsections that support an outcome where people receive quality services through effective governance and a supported workforce. | | Some subsections applicable to this service are partially attained and of low risk. |

Birchleigh Residential Care Centre has an established quality and risk management programme. The board is responsible for finance and risk, clinical governance, strategy and innovation and property. The board monitors performance of the company, with reports written by the management team for the board to discuss. The senior leadership team meet regularly to discuss key performance indicators, including quality and risk.

An established quality programme is documented. There is a comprehensive health and safety system in place with identified health and safety goals. Staff employed are provided with orientation and ongoing support through training. The training programme is in place with comprehensive records retained. Staff coverage is maintained for all shifts.

## Ngā huarahi ki te oranga | Pathways to wellbeing

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| Includes eight subsections that support an outcome where people participate in the development of their pathway to wellbeing, and receive timely assessment, followed by services that are planned, coordinated, and delivered in a manner that is tailored to their needs. | | Some subsections applicable to this service are partially attained and of medium or high risk and/or unattained and of low risk. |

The registered nurses, enrolled nurses and general practitioners assess residents on admission. The care plans are completed in partnership with residents. Care plans demonstrate service integration. Resident files included medical notes by the contracted general practitioner and visiting allied health professionals.

All staff responsible for administration of medication complete education and medication competencies. The medicine charts reviewed met prescribing requirements.

Residents' food preferences, dietary and cultural requirements are identified at admission. A current food control plan is in place. The kitchen staff cater to individual cultural and dietary requirements. There are snacks available 24 hours a day.

All transfers and discharges are coordinated with family/whānau.

## Te aro ki te tangata me te taiao haumaru | Person-centred and safe environment

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| Includes two subsections that support an outcome where Health and disability services are provided in a safe environment appropriate to the age and needs of the people receiving services that facilitates independence and meets the needs of people with disabilities. | | Subsections applicable to this service are fully attained. |

The building warrant of fitness was completed. Electrical equipment has been tested and tagged. All medical equipment has been serviced and calibrated.

## Te kaupare pokenga me te kaitiakitanga patu huakita | Infection prevention and antimicrobial stewardship

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| Includes five subsections that support an outcome where Health and disability service providers' infection prevention (IP) and antimicrobial stewardship (AMS) strategies define a clear vision and purpose, with quality of care, welfare, and safety at the centre. The IP and AMS programmes are up to date and informed by evidence and are an expression of a strategy that seeks to maximise quality of care and minimise infection risk and adverse effects from antibiotic use, such as antimicrobial resistance. | | Subsections applicable to this service are fully attained. |

All policies, procedures, the pandemic plan, and the infection control programme have been reviewed by the clinical nurse manager service and excellence and the nurse managers. Infection control education is provided to staff at the start of their employment, and as part of the annual education plan.

Surveillance data is documented, including the use of standardised surveillance definitions, and ethnicity data. There have been five outbreaks recorded since the last audit with these reported to the funder and to Public Health.

## Here taratahi | Restraint and seclusion

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| Includes four subsections that support outcomes where Services shall aim for a restraint and seclusion free environment, in which people's dignity and mana are maintained. | | Subsections applicable to this service are fully attained. |

There are restraints currently in use at Birchleigh Residential Care. The board are committed to minimising the use and eliminating restraint. Restraint minimisation is included as part of the education and training plan. The service considers least restrictive practices, implementing de-escalation techniques and alternative interventions, and uses approved restraints as the last resort.

## Summary of attainment

The following table summarises the number of subsections 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) |
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| **Subsection** | 0 | 16 | 0 | 1 | 2 | 0 | 0 |
| **Criteria** | 0 | 43 | 0 | 5 | 3 | 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) |
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| **Subsection** | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 |

# Attainment against the Ngā paerewa Health and disability services standard

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

For more information on the standard, please click here.

For more information on the different types of audits and what they cover please click here.

| Subsection with desired outcome | Attainment Rating | Audit Evidence |
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| Subsection 1.1: Pae ora healthy futures<br>Te Tiriti: Māori flourish and thrive in an environment that enables good health and wellbeing.<br>As service providers: We work collaboratively to embrace, support, and encourage a Māori worldview of health and provide high-quality, equitable, and effective services for Māori framed by Te Tiriti o Waitangi. | FA | A Māori health plan is documented for the service which acknowledges Te Tiriti o Waitangi as a founding document for New Zealand. Birchleigh Residential Care Centre is committed to respecting the self-determination, cultural values, and beliefs of Māori residents and whānau. Evidence of this commitment is documented in the resident's care plan and evidenced in practice. Access to cultural support and advice is available through Health New Zealand -Te Whatu Ora and through staff who identify as Māori when required. Comprehensive cultural assessments are completed for residents who identify as Māori.<br>Staff including four registered nurses, one enrolled nurse, six healthcare assistants, one maintenance, kitchen manager, and management (chief executive officer (CEO), three nurse managers, clinical nurse manager of service excellence) confirmed that the staff have completed cultural safety training and are proficient in discussing principles of Te Tiriti o Waitangi and applications within their roles. |
| Subsection 1.2: Ola manuia of Pacific peoples in Aotearoa<br>The people: Pacific peoples in Aotearoa are entitled to live and enjoy good health and wellbeing. | FA | The service has a current Pacific health plan which guides staff on how Pacific people who engage with the service are to be supported. Currently, there are no Pasifika residents or staff members at the facility. The CEO and |

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| Te Tiriti: Pacific peoples acknowledge the mana whenua of Aotearoa as tuakana and commit to supporting them to achieve tino rangatiratanga.<br>As service providers: We provide comprehensive and equitable health and disability services underpinned by Pacific worldviews and developed in collaboration with Pacific peoples for improved health outcomes. | | the clinical nurse manager (CNM) service excellence confirmed they have links through Health New Zealand, and their board if they required support in this area. Staff demonstrated an understanding of Pasifika culture, its relevance to their policies, and were knowledgeable about how to access community support for Pasifika individuals. |
| Subsection 1.3: My rights during service delivery<br>The People: My rights have meaningful effect through the actions and behaviours of others.<br>Te Tiriti:Service providers recognise Māori mana motuhake (self-determination).<br>As service providers: We provide services and support to people in a way that upholds their rights and complies with legal requirements. | FA | Birchleigh Residential Care Centre has an admission pack that details the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code), and there is an opportunity for residents and their families/whanau to discuss aspects of the Code during the admission process. Interviews with eleven families/whānau (three from the dementia unit, three requiring rest home level of care and five requiring hospital level of care) and eight residents (three from the rest home and five from the hospital) confirmed that they received information at admission which included the Code. Posters in large print featuring the Code and information on advocacy are prominently displayed across the facility in both English and te reo Māori. Both residents and families/whanau are briefed on the extent of services provided and any financial responsibilities for services not covered under the scope, all of which are detailed in the service agreement.<br>All managers and the CEO have an open-door policy that allows for the opportunity for residents to express their preferences with respect to areas such as care food, activities, and where they prefer to spend their time within the facility. If any issues are raised by residents or families/whānau, these are promptly addressed and followed up on as confirmed by residents and families/whanau interviewed.<br>Staff interviewed were knowledgeable about the Code and reported that they supported residents to know and understand their rights. |
| Subsection 1.5: I am protected from abuse<br>The People: I feel safe and protected from abuse.<br>Te Tiriti: Service providers provide culturally and clinically | FA | Birchleigh Residential Care Centre has implemented a comprehensive training program for all staff, focusing on the importance of maintaining professional boundaries. This training is updated regularly to address |

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| safe services for Māori, so they feel safe and are protected from abuse.<br>As service providers: We ensure the people using our services are safe and protected from abuse. | | emerging issues and reinforce the facility's zero-tolerance policy towards any form of abuse or discrimination. The effectiveness of this training is evident in the consistently positive feedback from resident and families/whānau satisfaction six-weekly and annual surveys, which highlight the respectful, compassionate care provided by the staff.<br><br>Residents and families/whānau stated that they can discuss any issues or concern with managers and the CEO at any time. Measures, alongside the policies and procedures already in place, demonstrate the facility's ongoing commitment to creating a safe, inclusive environment that respects the dignity and rights of all individuals in its care. There is no evidence of any abuse or neglect as confirmed by the CEO, managers, staff, and the general practitioner interviewed.<br><br>Systems are established to oversee the personal finances of residents. There are processes in place to manage resident's petty cash. The administrative staff maintain records of these transactions. Interviews with residents and families/whānau indicated resident's financial and property rights are upheld, and professional boundaries are consistently observed. |
| Subsection 1.6: Effective communication occurs<br><br>The people: I feel listened to and that what I say is valued, and I feel that all information exchanged contributes to enhancing my wellbeing.<br>Te Tiriti: Services are easy to access and navigate and give clear and relevant health messages to Māori.<br>As service providers: We listen and respect the voices of the people who use our services and effectively communicate with them about their choices. | FA | Residents and families/whānau interviewed provided positive feedback, noting that communication is open and effective, and they felt listened to. They expressed comfort in raising concerns with staff and management and consistently felt heard and understood.<br><br>Review of ten incident and accident reports confirmed that families/whānau were notified of any events or incidents. The contact details for families/whānau and the Enduring Power of Attorney (EPOA) were kept current, with a secondary contact noted when the EPOA was unavailable.<br><br>Recommendations relating to the previous shortfall (1.6.1) have been rectified. |
| Subsection 1.7: I am informed and able to make choices<br><br>The people: I know I will be asked for my views. My choices will be respected when making decisions about my wellbeing. If my choices cannot be upheld, I will be provided | FA | There are policies around informed consent. Resident files reviewed included completed general consent forms. Residents and families/whānau interviewed could describe what informed consent was and knew they had the right to choose. Consent forms of residents in the dementia unit were |

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| with information that supports me to understand why.<br>Te Tiriti: High-quality services are provided that are easy to access and navigate. Providers give clear and relevant messages so that individuals and whānau can effectively manage their own health,<br>keep well, and live well.<br>As service providers: We provide people using our services or their legal representatives with the information necessary to make informed decisions in accordance with their rights and their ability to exercise independence, choice, and control. | | appropriately signed by the activated enduring powers of attorney (EPOAs). All documentation regarding EPOAs and activation is on file. |
| Subsection 1.8: I have the right to complain<br><br>The people: I feel it is easy to make a complaint. When I complain I am taken seriously and receive a timely response.<br>Te Tiriti: Māori and whānau are at the centre of the health and disability system, as active partners in improving the system and their care and support.<br>As service providers: We have a fair, transparent, and equitable system in place to easily receive and resolve or escalate complaints in a manner that leads to quality improvement. | FA | The complaints procedure is an equitable process that is provided to all residents and families/whānau on entry to the service. The CNM service excellence has overall responsibility for ensuring all complaints (verbal or written) are fully documented and investigated. Birchleigh Residential Care Centre has up to date complaints register. Concerns and complaints are discussed at relevant meetings.<br><br>There have been two internal complaints made in 2023 and three in 2024 year to date. There have been no external complaints received. The complaints were reviewed and these, along with a review of the complaint register, showed that all complaints were managed in accordance with the Health and Disability Commissioner (HDC) Code. All concerns were addressed promptly, and resolution was documented and residents and families/whānau were informed of the outcome.<br><br>Residents, and families/whānau stated that they have a variety of avenues they can choose from to make a complaint or express a concern. Interviews with the CEO, the CNM service excellence manager and nurse managers confirmed their understanding of the complaints process. Document review and staff interviews confirmed that the complaints process works equitably for Māori and support is available. The senior leadership articulated their understanding that face to face meetings with whānau are preferred in resolving any issues for Māori. |

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| Subsection 2.1: Governance<br><br>The people: I trust the people governing the service to have the knowledge, integrity, and ability to empower the communities they serve.<br>Te Tiriti: Honouring Te Tiriti, Māori participate in governance in partnership, experiencing meaningful inclusion on all governance bodies and having substantive input into organisational operational policies.<br>As service providers: Our governance body is accountable for delivering a highquality service that is responsive, inclusive, and sensitive to the cultural diversity of communities we serve. | FA | Birchleigh Residential Care is a care facility located in Mosgiel. The service provides care for up to 83 residents at rest home, hospital level care and dementia level of care. There was a double room in use on the days of the audit. Four of the ten dual purpose beds in the rest home area which were verified at the previous partial provisional/certification audit were occupied with hospital residents on the days of the audit. This audit also verified a previous hospital level double room to be suitable for dual purpose (rest home and hospital) care. The room is large enough to accommodate two residents.<br><br>On the day of the audit there were 80 residents: 28 rest home, 24 dementia and 28 hospital including one resident on respite, and one resident on an ACC contract. All other residents were under aged residential care service agreements.<br><br>Birchleigh Residential Care has a strategic plan in place that has been reviewed in 2023 and continues in place. There are clear business goals to support the Birchleigh Residential Care philosophy of caring isn't what we do it's what we are. The CEO reports to a board of three. The board receives monthly board reports from the CEO, the nurse managers and the CNM service excellence. The board has a well described structure, purpose, values, scope, direction, performance, and goals and these are monitored and reviewed annually. The board has a commitment to ensure the service achieves equity, improves outcomes for Māori, and ensure barriers are identified so staff are able to minimise barriers to equitable service delivery. The CEO explained there is collaboration with Māori that aligns with Health New Zealand strategies and addresses barriers to equitable service delivery.<br><br>The facility is managed by the CEO who has worked for Birchleigh Residential Care for eighteen years. The CEO is supported by the CNM service excellence (registered nurse), who has extensive experience as a registered nurse; however, is new to aged care and works alongside three nurse managers, two of whom have worked in aged care for many years.<br><br>The working practices at Birchleigh Residential Care are holistic in nature, inclusive of cultural identity, spirituality and respect the connection to families/whānau and the wider community as a fundamental aspect of wellbeing and improved health outcomes. The clinical governance is appropriate to the size and complexity of the service provision. The quality |

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| | | programme includes a quality programme policy, and quality goals that are reviewed monthly in meetings, are completed for any quality improvements/initiatives during the year. The goals are reviewed at management meetings and by the board. A risk/hazard register is also documented with this identifying potential hazards, associated risks, control type, controls in place, risk assessment and person responsible. |
| Subsection 2.2: Quality and risk<br><br>The people: I trust there are systems in place that keep me safe, are responsive, and are focused on improving my experience and outcomes of care.<br>Te Tiriti: Service providers allocate appropriate resources to specifically address continuous quality improvement with a focus on achieving Māori health equity.<br>As service providers: We have effective and organisation-wide governance systems in place relating to continuous quality improvement that take a risk-based approach, and these systems meet the needs of people using the services and our health care and support workers. | PA Low | Birchleigh Residential Care Centre is implementing a well-documented quality and risk management programme. The quality and risk management systems include performance monitoring through internal audits and through the collection of clinical indicator data. Quality indicators are documented, graphed, analysed and results discussed at the monthly quality improvement meetings. Quality indicators discussed include infections and Covid-19 cases, multidrug-resistant organisms (MDROs), deaths, admissions, occupancy, staff health and safety, adverse events, rostering, wound care, ethnicity of residents.<br><br>A range of meetings are scheduled. These include a monthly quality improvement meeting and separate management meeting. Both the quality improvement meeting and management meeting includes quality improvement data, health and safety, infection prevention and control. Other meetings include two to three monthly clinical RN meetings and quarterly staff meetings in each area facilitated by the nurse manager. Meeting minutes confirmed that discussions include quality data, health and safety, infection prevention and control/outbreak management, complaints received (if any), staffing, and education. There is a comprehensive audit schedule which each nurse manager completes for their area and any corrective actions required are planned for and documented. The audit schedule was completed for the Silverstream (rest home) area; however, the audit schedule was partially completed for the Braeside (hospital) and Janefield (dementia) area.<br><br>Each residents' families/whānau is given the opportunity to provide feedback at six weeks after admission by an electronic survey that is sent to them. The results of the six-week survey go directly to the nurse manager who responds to them and reports any feedback, compliments, and concerns in their monthly reports. Further to this an annual survey is sent to residents' families/whānau. The February 2024 survey had 85% satisfaction |

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| | | in privacy/dignity/rights, medical services, and assistance. A number of corrective actions have been actioned from this survey.<br><br>A comprehensive health and safety system in place with identified health and safety goals. The health and safety committee meets as part of the monthly quality meeting and discusses a range of topics covered including work related risks, opportunities for improvements, and topics related to staff, residents, and visitors' wellbeing. The hazard and risk registers detail the risk and how each risk is mitigated and controlled. These are reviewed annually and were up to date with risks currently in the service. Contractor's sign into the village and they are orientated to the facility prior undertaken their work.<br><br>All resident adverse events are recorded on the electronic system. Ten adverse event forms were reviewed and evidenced immediate action noted and any follow-up action(s) required including notifying families/whānau and any post adverse event follow ups. Data is collated monthly and analysed. Results are discussed in the relevant meetings and at handovers. Each event involving a resident reflected a clinical assessment and follow-up by a nurse manager or registered nurse.<br><br>Discussions with the CNM service excellence and nurse managers evidenced awareness of their requirement to notify relevant authorities in relation to essential notifications. There have been section 31 notifications completed to notify HealthCERT of the change of CNM – service excellence manager as well as notifications for stage three and four pressure injuries. Along with these, two severity assessment code (SAC) notifications have been made to the Health Quality Safety Commission (HSQC) for pressure injuries. However, a further three pressure injuries requiring SAC notifications have not been evidenced as reported to the HQSC, note all families/whānau notifications have been made. Notifications have been sent appropriately for all infectious outbreaks. |
| Subsection 2.3: Service management<br><br>The people: Skilled, caring health care and support workers listen to me, provide personalised care, and treat me as a whole person.<br>Te Tiriti: The delivery of high-quality health care that is | FA | Birchleigh Residential Care Centre employs a total of 130 staff across the service. The roster provides appropriate coverage for the effective delivery of care and support. The workforce has been stable. There is a full-time pm supervisor (RN) that is on site after hours. The three nurse managers and CNM service excellence work Monday to Friday and share on call cover. |

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| culturally responsive to the needs and aspirations of Māori is achieved through the use of health equity and quality improvement tools.<br>As service providers: We ensure our day-to-day operation is managed to deliver effective person-centred and whānau-centred services. | | The CEO works Monday to Friday and is available out of hours if required.<br><br>The annual education and training schedule is being implemented for 2024. The education and training schedule lists compulsory training which includes cultural awareness training, dementia, abuse and neglect, death and dying and infection prevention and control. Staff last attended cultural awareness training in 2023-24, and all staff completed a cultural competency to reflect their understanding of providing safe cultural care, te ao Māori and Te Tiriti o Waitangi. External training opportunities for registered nurses and health care assistants include training through Health New Zealand, hospice.<br><br>The service supports and encourages healthcare assistants to obtain a New Zealand Qualification Authority (NZQA) qualification. There are 67 healthcare assistants (HCAs) employed. The orientation programme ensures core competencies and compulsory knowledge/topics are addressed. Forty HCAs have achieved NZQA level three or level four. Janefield (dementia unit) has 23 HCAs who work there. HCAs working in the dementia unit for more than 18 months have completed the required dementia standards. Two staff are currently working on the dementia standards and have been employed within the last 18 months.<br><br>A competency assessment policy is implemented. All staff are required to complete competency assessments as part of their orientation. All HCAs are required to complete annual competencies for restraint, hand hygiene, correct use of personal protective equipment (PPE), cultural safety and moving and handling. A record of completion is maintained on an electronic register. The previous shortfall (2.3.3) has been addressed.<br><br>Five of the nine registered nurses including the nurse managers are interRAI trained. There is external training, webinars and zoom trainings which registered nurses are encouraged to attend. |
| Subsection 2.4: Health care and support workers<br><br>The people: People providing my support have knowledge, skills, values, and attitudes that align with my needs. A diverse mix of people in adequate numbers meet my needs. Te Tiriti: Service providers actively recruit and retain a Māori | FA | Human resource policies and procedures are in place, including recruitment, selection, orientation and staff training and development. Seven staff files reviewed evidenced implementation of the recruitment process, employment contracts, police checking and completed orientation. An orientation programme is completed for each role and provides new staff with relevant information for safe work practice. Employment records included signed |

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| health workforce and invest in building and maintaining their capacity and capability to deliver health care that meets the needs of Māori.<br>As service providers: We have sufficient health care and support workers who are skilled and qualified to provide clinically and culturally safe, respectful, quality care and services. | | code of conduct and house rules.<br>A register of practising certificates is maintained for all health professionals. All staff files reviewed had an annual appraisal completed. |
| Subsection 3.2: My pathway to wellbeing<br>The people: I work together with my service providers so they know what matters to me, and we can decide what best supports my wellbeing.<br>Te Tiriti: Service providers work in partnership with Māori and whānau, and support their aspirations, mana motuhake, and whānau rangatiratanga.<br>As service providers: We work in partnership with people and whānau to support wellbeing. | PA Moderate | Six residents' files were reviewed including three hospital level of care (including one respite and one resident on an ACC contract), one rest home level of care and two dementia level of care. The registered nurses are responsible for completing the admission assessments, care planning and care plan evaluations. The initial nursing assessments and initial care plans sampled were developed within 24 hours of an admission in consultation with the residents, EPOAs and families/whānau where appropriate, with resident's consent. The social history questionnaire used includes consideration of residents' lived experiences, cultural needs, values, and beliefs.<br>The residents who identified as Māori have a Māori health care plan in place which describes the support required to meet their needs. Care plans addressed cultural preferences. Staff have access to Māori and Pasifika advisors if a cultural support is needed. Residents confirmed they can practice their culture as desired.<br>A range of clinical assessments, referral information, observation and the preadmission assessments served as a basis for care planning. Four of the six files reviewed had current interRAI assessments. InterRAI assessments were not required for the respite and ACC residents. These residents had appropriate risk assessments completed which linked to their care plans long term care plans (LTCPs) are developed with input from residents, families/whānau, HCAs, registered nurses and activities staff; however, not all files reviewed evidenced this occurred within required timeframes. The LTCPs are developed by registered nurses and are holistic, covering physical needs, assistance required with activities of daily living, psychosocial and cultural needs and aspirations and interventions to address and medical conditions; however, not all interventions were documented in sufficient detail to guide staff. The previous shortfall (3.2.3) |

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| | | remains ongoing. Routine evaluations of LTCPs were completed although not always as scheduled and plans did not always include the residents' degree of progress towards their agreed goals and aspirations as well as families/whānau goals and aspirations. Where progress was different from expected, the LTCP was not always updated to reflect the changes. Where there was a significant change in the resident's condition, a referral was made to the local needs assessment service coordination (NASC) team for reassessment for level of care. Behaviour management plans were completed for residents in the dementia unit and where applicable for other residents. Triggers were identified and strategies to manage these were documented. Behaviours that challenge were monitored and recorded on the behaviour monitoring charts. Short-term care plans were completed for acute conditions and reviewed regularly as clinically indicated and signed off when the conditions resolved.<br><br>There were 24 active wounds at the time of the audit, including skin tears, abrasions and six pressure injuries. A sample review found that a number of wounds were incorrectly classified and not all wounds were documented on individual wound management plans. Wound management plans were implemented with regular evaluations; however, dressing changes did not always occur as scheduled. Referrals to wound management specialist and dietitian were completed, where required. The registered nurses confirmed there are always adequate wound management supplies in stock and the nurse managers oversee the wound management in each area.<br><br>A range of monitoring charts are available for the care staff to utilise. These include (but not limited to) monthly blood pressure and weight monitoring, bowel records and repositioning chart, blood glucose levels, including neurological observation and fluid balance monitoring; however, not all monitoring was evidenced as occurring as scheduled.<br><br>Service integration with other health providers including medical and allied health professionals was evident in residents' records reviewed. Changes in residents' health were escalated to the general practitioners in a timely manner. Referrals to specialist services were completed, where required. Evidence of this was available in the residents' files sampled. Referrals sent to specialist services included referrals to the mental health services for older adults, eye specialist, wound care nurse specialist and dietician. The general practitioner interviewed stated that there was good communication with the service, they were informed of concerns in a timely manner, that |

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| | | medical orders were followed, and care was implemented promptly. Residents were transferred to other health care providers when required. The general practitioner expressed satisfaction with the care provided.<br><br>Medical assessments were completed by the general practitioners within two to five working days of an admission. Routine medical reviews and medication chart reviews were not always completed three-monthly (link 3.4.1). More frequent reviews were completed if required as determined by the resident's needs. The GP stated they were happy with all aspect of care and stated the communication from nursing staff was excellent. Medical records were evident in sampled records. There is a contracted podiatrist who visits the service six-weekly, and a contracted physiotherapist who completes assessments of residents and manual handling training for staff. Residents' care was evaluated on each shift and documented in the progress notes by the HCAs. Resident's health changes were reported to the registered nurses and the nurse managers, as confirmed in the records sampled and in interviews with HCAs.<br><br>Residents' records, observations, and interviews verified that care provided to residents was consistent with their assessed needs, goals, and aspirations. A range of equipment and resources were available, suited to the levels of care provided and in accordance with the residents' needs. Residents and families/whānau confirmed their involvement in evaluation of progress, any resulting changes, and they confirmed satisfaction with the care provided. |
| Subsection 3.4: My medication<br><br>The people: I receive my medication and blood products in a safe and timely manner.<br>Te Tiriti: Service providers shall support and advocate for Māori to access appropriate medication and blood products.<br>As service providers: We ensure people receive their medication and blood products in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate | The medication management policy is current and in line with current legislative requirements. A safe system for medicine management was in use. A registered nurse was observed administering medications safely and correctly in the dementia unit. The system described medication prescribing, dispensing, administration, review, and reconciliation. Administration records were maintained. Medications are supplied to the facility from a contracted pharmacy.<br><br>A total of 12 medicine charts were reviewed. The prescribing practices included the prescriber's name and date recorded on the commencement and discontinuation of medicines and all requirements for pro ne rata (PRN) |

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| | | medicines; however, effectiveness of PRN medications was not consistently documented in either the medication system or in progress notes. Medication allergies and sensitivities were not always documented on the resident's chart where applicable and not all photographs had been updated as per policy. The three-monthly medication reviews were not consistently recorded on the medicine charts sampled.<br><br>The service uses pre-packaged medication rolls. The medication and associated documentation were stored safely with restricted access. Controlled drug medications were safely stored in each area; however, weekly stock checks have not been consistently completed as per legislative requirements. The previous shortfall 3.4.1 remains ongoing. Medication reconciliation was conducted by the RNs when regular medicine packs were received from the pharmacy and when a resident was transferred back to the service. This was verified in medication records sampled. Medicine sampled for review were within current use by dates. Unwanted medicine was returned to the pharmacy in a timely manner. This is an improvement since the previous since audit. The records of temperatures for the medicine fridges and the medication rooms sampled were within the recommended range. Opened eyedrops were dated. Appropriate processes were in place for the management of standing orders.<br><br>There were residents who were self-administering medicine on the days of the audit. Appropriate processes were in place to ensure residents' self-medication administration was managed in a safe manner. There is an implemented process for comprehensive analysis of medication errors and corrective actions implemented as required. Medication audits were not completed in all areas, audits that had been completed had corrective action plans implemented as required (link 2.2.3). |
| Subsection 3.5: Nutrition to support wellbeing<br><br>The people: Service providers meet my nutritional needs and consider my food preferences.<br>Te Tiriti: Menu development respects and supports cultural beliefs, values, and protocols around food and access to traditional foods.<br>As service providers: We ensure people's nutrition and | FA | Residents' nutritional requirements are assessed on admission to the service in consultation with the residents and family/whānau. The nutritional assessments identify residents' personal food preferences, allergies, intolerances, any special diets, cultural preferences, and modified texture requirements. Copies of individual dietary preference were available in the kitchen folder. Resident preferences are considered with menu reviews.<br><br>The current food control plan will expire on 30 April 2025. Residents and |

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| hydration needs are met to promote and maintain their health and wellbeing. | | families/whānau interviewed expressed their satisfaction with the meal service. |
| Subsection 3.6: Transition, transfer, and discharge<br><br>The people: I work together with my service provider so they know what matters to me, and we can decide what best supports my wellbeing when I leave the service.<br>Te Tiriti: Service providers advocate for Māori to ensure they and whānau receive the necessary support during their transition, transfer, and discharge.<br>As service providers: We ensure the people using our service experience consistency and continuity when leaving our services. We work alongside each person and whānau to provide and coordinate a supported transition of care or support. | FA | Transfers and discharges are managed efficiently in consultation with the resident, EPOA, families/whānau and the general practitioner. Appropriate documentation and relevant clinical and medical notes were provided to ensure continuity of care when residents were transferred. The reason for transfer was documented on the transfer records and progress notes in the sampled files. The transfer and discharge planning included risk mitigation and current needs of the resident. |
| Subsection 4.1: The facility<br><br>The people: I feel the environment is designed in a way that is safe and is sensitive to my needs. I am able to enter, exit, and move around the environment freely and safely.<br>Te Tiriti: The environment and setting are designed to be Māori-centred and culturally safe for Māori and whānau.<br>As service providers: Our physical environment is safe, well maintained, tidy, and comfortable and accessible, and the people we deliver services to can move independently and freely throughout. The physical environment optimises people's sense of belonging, independence, interaction, and function. | FA | The planned maintenance schedule includes testing and tagging of electrical equipment by onsite maintenance staff (electrician), monthly generator checks resident's equipment checks, and calibrations of the weighing scales and clinical equipment. The scales are checked annually. Hot water temperatures were monitored monthly, and the reviewed records were within the recommended ranges. Reactive maintenance is carried out by the maintenance staff and certified tradespeople where required. The environmental temperature is monitored and there were implemented processes to manage significant temperature changes.<br><br>The building warrant of fitness was current and will expire on 4 March 2025. Birchfield Residential Care has been proactive in improving the service and facilities. The Janefield dementia unit has been enhanced by the use of coloured padded grass and pathways assisting residents to mobilise safely, a gate with opaque panels to prevent injury when opening, a bus shelter for residents to use as an outdoor activity and increased use of camera surveillance ensuring all public areas are visible. The doors of dementia residents rooms and toilets have been painted in contrasting colours to increase visibility. In addition, ramps have been added to Silverstream |

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| | | rooms with external exits improving egress. The nurse call system and heating and cooling systems have been upgraded and an additional 3000 litre water storage tank has been installed. The designated double hospital level room has been reconfigured to dual purpose to accommodate the current occupants (one is rest home and the other is hospital). This was verified as being suitable for use. There is adequate space for hospital level equipment and privacy is maintained.<br><br>The environment is inclusive of people's cultures and supports cultural practices. Residents can bring personal items to furnish their rooms. |
| Subsection 5.2: The infection prevention programme and implementation<br><br>The people: I trust my provider is committed to implementing policies, systems, and processes to manage my risk of infection.<br>Te Tiriti: The infection prevention programme is culturally safe. Communication about the programme is easy to access and navigate and messages are clear and relevant.<br>As service providers: We develop and implement an infection prevention programme that is appropriate to the needs, size, and scope of our services. | FA | The infection prevention and control programme is appropriate for the size and complexity of the service and is reviewed annually. The programme is linked to the quality improvement programme and approved by the board. The infection prevention and control policies were developed by an external quality improvement specialist, and these comply with relevant legislation and accepted best practice. The nurse manager of Janefield (dementia area) is the infection prevention and control coordinator and is new to the role.<br><br>Staff have received education in infection prevention and control at orientation and through ongoing annual online education sessions. A review of staff training records evidenced that staff mandatory infection prevention and control was up to date with all staff attending. Additional staff education around the prevention and management of infectious outbreaks is ongoing. This includes reminders about handwashing and advice about remaining in their room if they are unwell. Staff who were interviewed demonstrated a good understanding of infection prevention and control measures. |
| Subsection 5.4: Surveillance of health care-associated infection (HAI)<br><br>The people: My health and progress are monitored as part of the surveillance programme.<br>Te Tiriti: Surveillance is culturally safe and monitored by ethnicity.<br>As service providers: We carry out surveillance of HAIs and | FA | The infection surveillance program is tailored to the facility's size and service complexity, with thorough monitoring and management of infections. Advice around infection prevention and control matters is sought from the infection prevention and control specialist at Health New Zealand and by liaising with GPs.<br><br>Monthly data on various infections, including those affecting the urinary tract, skin, eyes, respiratory system, and wounds is collected, based on |

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| multi-drug-resistant organisms in accordance with national and regional surveillance programmes, agreed objectives, priorities, and methods specified in the infection prevention programme, and with an equity focus. | | signs, symptoms, and infection definitions. This information is logged into an electronic infection register and detailed in a monthly infection summary, where infections, including specific organisms, are reviewed and improvements at a RN and staff level are documented in meeting minutes including in the infection prevention and control meeting minutes. The infection prevention and control data captures information on ethnicity.<br><br>Covid - 19 outbreaks have been managed as per policy with two in 2023 and two in 2024. Further to this an outbreak of an MDRO occurred in June 2023 and is yet to be considered as able to be closed. This outbreak has been kept within Braeside (hospital) with all staff receiving regular infection prevention and control education specific to the MDRO. Outbreaks are discussed at board meetings through receipt of the nurse managers reports. Staff interviewed were knowledgeable around isolation practices and appropriate use of personal protective equipment. |
| Subsection 6.1: A process of restraint<br><br>The people: I trust the service provider is committed to improving policies, systems, and processes to ensure I am free from restrictions.<br>Te Tiriti: Service providers work in partnership with Māori to ensure services are mana enhancing and use least restrictive practices.<br>As service providers: We demonstrate the rationale for the use of restraint in the context of aiming for elimination. | FA | The governance body are aware of their responsibilities in respect of restraint minimisation. Restraint minimisation and safe practice is linked to the organisational quality and risk management strategies. Restraint information is presented at quality meetings and in individual nurse manager reports to the board. The restraint coordinator discusses individual restraint at relevant meetings. Annual restraint review meetings are held as part of the quality meeting. The restraint coordinator described strategies in place to minimise and eliminate restraint including the use of alternative methods.<br><br>At the time of the audit, there were nine residents (two dementia and seven hospital) using restraint. Staff have received education on dementia, challenging behaviour management, restraint minimisation, alternative cultural-specific interventions, and de-escalation techniques. |

# Specific results for criterion where corrective actions are required

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

Criterion can be linked to the relevant subsection by looking at the code. For example, Criterion 1.1.1 My service provider shall embed and enact Te Tiriti o Waitangi within all its work, recognising Māori, and supporting Māori in their aspirations, whatever they are (that is, recognising mana motuhake) relates to subsection 1.1: Pae ora healthy futures in Section 1 Our 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) |
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| Criterion 2.2.3<br>Service providers shall evaluate progress against quality outcomes. | PA Low | Birchleigh Residential Care Centre has a well-documented quality and risk management programme. The quality and risk management systems include performance monitoring through internal audits. A comprehensive audit schedule is in place. Each nurse manager completes the audits for their area and any corrective actions required are planned for and documented. The audit schedule was completed for the Silverstream rest home area; however, the audit schedule was partially completed for the Braeside (hospital) and Janefield (dementia) areas. | Braeside (hospital) and Janefield (dementia) areas had not completed all scheduled audits for medication management, mini clinical record audit, pressure injury prevention management, wound and skin care, falls management and neurological observations. | Ensure the internal audit schedule is completed as planned.<br><br>90 days |
| Criterion 2.2.6 | PA Low | The management of adverse events is | Three of 13 current pressure | Ensure all adverse |

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| Service providers shall understand and comply with statutory and regulatory obligations in relation to essential notification reporting. | | clearly described in policy that has been updated to include the notification requirements to reflect the change in notification pathway from 1 July 2024 to HQSC. The CNM service excellence and nurse managers were interviewed understood which events require essential notifications. A review of adverse event forms and wound management plans revealed that three pressure injuries had not been assessed correctly, therefore were not reported to HQSC (link 3.2.4). Note all adverse event forms were completed and families/whanau had been advised of the pressure injuries | injuries were not reported through to HQSC as required. | events are reported through the incident reporting system to effectively respond to risks.<br><br>90 days |
| Criterion 3.2.1<br><br>Service providers shall engage with people receiving services to assess and develop their individual care or support plan in a timely manner. Whānau shall be involved when the person receiving services requests this. | PA Low | All assessments are completed by a RN in partnership with residents and families/whānau. An initial summary care plan is developed within 24 hours of admission to provide guidance for HCAs on care delivery for the residents. This was sighted in six resident files. For the sample files reviewed, all residents who required an initial interRAI and interRAI reassessments had this completed within required timeframes. The initial LTCP was completed as required for three of the six residents (two had not been at the service for three weeks); however, timeframes were not completed as required for one resident. Six-monthly reviews where required were completed; however, not always within required timeframes. | i). One hospital level resident had their first long LTCP completed over four months after admission.<br><br>ii). Two of two residents (dementia) who required LTCP evaluations did not have these always completed within required timeframes. | i-ii). Ensure LTCPs and evaluations are competed within required timeframes.<br><br>90 days |

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| Criterion 3.2.3<br><br>Fundamental to the development of a care or support plan shall be that:<br>(a) Informed choice is an underpinning principle;<br>(b) A suitably qualified, skilled, and experienced health care or support worker undertakes the development of the care or support plan;<br>(c) Comprehensive assessment includes consideration of people's lived experience;<br>(d) Cultural needs, values, and beliefs are considered;<br>(e) Cultural assessments are completed by culturally competent workers and are accessible in all settings and circumstances. This includes traditional healing practitioners as well as rākau rongoā, mirimiri, and karakia;<br>(f) Strengths, goals, and aspirations are described and align with people's values and beliefs. The support required to achieve these is clearly documented and communicated;<br>(g) Early warning signs and risks that may adversely affect a person's wellbeing are recorded, with a focus on prevention or escalation for appropriate intervention;<br>(h) People's care or support plan identifies wider service integration as required. | PA Moderate | The service has comprehensive policies related to assessment, support planning and care evaluation. Registered nurses are responsible for completing assessments (including interRAI), developing resident centred care interventions, and evaluating the care delivery six-monthly or earlier as residents needs change. The service seeks multidisciplinary input as appropriate to the needs of the resident. Care plan evaluations identify goals; however, not all resident records reviewed provided evidence of detailed interventions to provide guidance to care staff in the delivery of care to the residents. This is an ongoing shortfall.<br><br>Supplementary documentation reviewed and interviews with resident, family/whānau and care staff identified that the shortfalls noted relate to documentation only and the residents received the required care. | i). Three of nine residents utilising restraint did not have the use of restraint documented in the LTCP.<br><br>ii). The LTCP of one dementia resident utilising a body suit restraint did not have interventions documented for toileting, behaviours, activities of daily living or management strategies for restraint application and monitoring.<br><br>iii). Two of eight residents utilising restraint did not evidence approval or assessment documentation.<br><br>iv). One hospital resident with a history of frequent falls, behaviours of concern and wandering did not include sufficient interventions to guide management of care.<br><br>v). One dementia level care resident with recent weight loss and increased pain did not include sufficient interventions to guide care. | i-v). Ensure LTCPs have detailed interventions documented to provide guidance to care staff on care management.<br><br>60 days |

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| Criterion 3.2.4<br><br>In implementing care or support plans, service providers shall demonstrate:<br>(a) Active involvement with the person receiving services and whānau;<br>(b) That the provision of service is consistent with, and contributes to, meeting the person's assessed needs, goals, and aspirations. Whānau require assessment for support needs as well. This supports whānau ora and pae ora, and builds resilience, self-management, and self-advocacy among the collective;<br>(c) That the person receives services that remove stigma and promote acceptance and inclusion;<br>(d) That needs and risk assessments are an ongoing process and that any changes are documented. | PA Moderate | A range of monitoring charts are available for the care staff to utilise. Monthly observations such as weight and blood pressure were completed and are up to date. The wound register was reviewed; however, did not include individual management plans for all current wounds. Wound management plans were reviewed; however, wounds were not always correctly assessed and staged. Where there was more than wound the management plans did not always follow policy. Progress notes were documented each shift by HCAs and as required by RN's. Policies related to monitoring requirements for restraint and neurological observations identify responsibilities for documentation and monitoring; however, this was not consistently evidenced. | i). Eight of nine residents utilising restraint did not evidence check and release as per policy.<br><br>ii). Eight of eight residents on repositioning charts did not evidence completion as per policy.<br><br>iii). One resident with chronic wounds on both legs had both wounds documented on one chart.<br><br>iv). Five of eight wounds reviewed did not evidence dressings were completed as scheduled.<br><br>v). Five of six pressure injuries reviewed were not correctly staged in the wound log.<br><br>vi). Four of six neurological observations reviewed were not completed as per policy. | i-ii). Ensure restraint and repositioning charts are completed as scheduled.<br><br>iii-v). Ensure wounds are documented on individual wound management plans, staged correctly and that dressings are completed as scheduled.<br><br>vi). Ensure neurological observations are completed as per policy.<br><br>60 days |
| Criterion 3.2.5<br><br>Planned review of a person's care or support plan shall:<br>(a) Be undertaken at defined intervals in collaboration with the person and whānau, together with wider service providers;<br>(b) Include the use of a range of outcome measurements; | PA Low | As per policy, the registered nurse is responsible for assessments and documentation of care plans. There was evidence of assessment updates and evaluations conducted for residents; however, evaluations did not always evidence progress towards goals. | Evaluation of progress towards goals was not included in three of six, six monthly LTCP reviews (one hospital and two dementia). | Ensure evaluations document progress towards care plan goals.<br><br>90 days |

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| (c) Record the degree of achievement against the person's agreed goals and aspiration as well as whānau goals and aspirations;<br>(d) Identify changes to the person's care or support plan, which are agreed collaboratively through the ongoing re-assessment and review process, and ensure changes are implemented;<br>(e) Ensure that, where progress is different from expected, the service provider in collaboration with the person receiving services and whānau responds by initiating changes to the care or support plan. | | | | |
| Criterion 3.4.1<br>A medication management system shall be implemented appropriate to the scope of the service. | PA Moderate | Medication is charted electronically by a general practitioner; however, three-monthly reviews are not consistently documented. Policy requirements include an up-to-date photograph of each resident; however, this was not consistently evidenced. The registered and enrolled nurses and medication competent HCAs are responsible for the administration of medications. Those responsible for medication administration have all completed medication competencies and education related to medication management. There is a policy and process on safe medicine management including reconciliation, storage, and documentation requirements including weekly controlled drug checks; however, not all checks occurred as scheduled. | i). Effectiveness of PRN medication was not consistently documented in five of 12 medication files reviewed.<br>ii). Two of 12 three monthly medication reviews by the general practitioner were overdue at the time of the audit.<br>iii). Weekly controlled drug medication checks have not been completed consistently in the hospital wing.<br>iv). Five of 12 resident medications files evidenced photographs which had not been reviewed for between one and two years. | i). Ensure the effectiveness of PRN medication is documented.<br>ii). Ensure medical reviews are completed and documented three monthly.<br>iii). Ensure controlled drug stock medication checks are completed as per legislative requirements.<br>iv). Ensure resident photographs on medication charts are current as per policy. |

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| | | The electronic system and progress notes are utilised to record the effectiveness of PRN medications; however, this was not consistent for all PRN administration. Staff have received training related to medicine management and medication related audits have been completed in line with the audit schedule. | | 60 days |
| Criterion 3.4.4<br>A process shall be implemented to identify, record, and communicate people's medicinerelated allergies or sensitivities and respond appropriately to adverse events. | PA Low | Medication is charted electronically by a general practitioner; however, allergies are not always documented as per policy. | Medicine allergies were not documented on three of 12 medication charts reviewed | Ensure medication allergies are identified and documented on medication charts.<br><br>90 days |

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

As well as whole subsections, individual criterion within a subsection 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 subsection by looking at the code. For example, Criterion 1.1.1 relates to subsection 1.1: Pae ora healthy futures in Section 1: Our rights.

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

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End of the report.