Sodhi Enterprises Limited - Coronation Lodge Rest Home

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:	Sodhi Enterprises Limited
Premises audited:	Coronation Lodge Rest Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 26 October 2021 End date: 27 October 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: 21

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Coronation Lodge Rest Home is privately owned under the current management for two and a half years. Coronation Lodge Rest Home provides rest home level care for up to 22 residents. On the day of the audit there were 21 residents residing at the facility.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management, and staff.

The facility manager/owner and clinical nurse manager/owner are responsible for the daily operations of the business. The managers are supported by an operations manager/cook, caregivers, and support staff. Residents and family member interviewed were complimentary of the service they receive.

Previous findings around staff references and care plan interventions have been addressed.

There are no shortfalls identified at this audit.

The service has been awarded a continuous improvement rating for reduction of falls.

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.

The service communicates effectively with residents and relatives. There are resident meetings held two monthly which provide an opportunity to feedback on the services provided. The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) brochures and complaint forms are accessible to residents and their families. Complaints processes are implemented and managed in line with the Code.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.

The quality and risk management plan and quality and risk policies describe Coronation Lodge's quality improvement processes. Policies and procedures are maintained by an external aged care consultant who ensures they align with current good practice. Quality data is collated for infections, accident/incidents, concerns and complaints, internal audits, and surveys. Quality data is discussed at meetings and is documented in minutes. Adverse, unplanned, and untoward events are documented by staff. There is an implemented health and safety programme.

Staff files included all appropriate employment documentation. The service has an orientation programme that provides new staff with relevant information for safe work practice. There is an education programme covering relevant aspects of care and external training is supported. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

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.

The clinical nurse manager is responsible for completing initial assessments, interRAI assessments, care plans and evaluations within the required timeframes. Resident files include allied health professional involvement. The general practitioner reviews residents at least three- monthly.

The activity programme is varied and interesting and meets the preferences and individual abilities of the residents. There are visiting entertainers (when permitted) and daily van rides. Residents are encouraged to maintain community links.

Medicines are stored and managed appropriately in line with legislation and guidelines. The RNs and senior caregivers' complete medication competencies and medication education. The general practitioner reviews the medication charts at least three-monthly.

Meals are prepared and cooked on site. The menu is varied, appropriate and reviewed by a dietitian. Resident dislikes are known and accommodated. Residents interviewed were complimentary about the food service.

Safe and appropriate environment

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

The building has a current warrant of fitness. There is a reactive and planned maintenance system in place. The facility is well maintained and there is sufficient equipment available to safely deliver resident cares.

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.

Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of approved restraints and enabler. Staff receive regular education and training on restraint minimisation. At the time of the audit there was one resident who required bedrails as an enabler for safety and one resident who required environmental restraint.

Infection prevention and control

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

The infection control coordinator (clinical nurse manager) is responsible for the collation of infection events. Information obtained through surveillance is discussed at staff meetings and used to identify trends, quality improvements and training and education for staff. There is a Covid resurgence plan in place, screening, and sufficient personal protective equipment available.

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	17	0	0	0	0	0
Criteria	1	42	0	0	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
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	There is a complaints policy to guide practice that aligns with Right 10 of the Code of Health and Disability Services Consumer Rights (The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). A complaints register is maintained. Compliments and concerns/complaints are discussed during the monthly staff meeting. Complaints forms are visible within the main entrance to the facility. There has been one internal concern for 2020 and one written complaint for 2021 to date. Both were investigated with outcomes discussed with staff. The formal complaint was closed out with a letter offering independent advocacy should the complainant not be satisfied with the outcome. The facility manager is the privacy officer and responsible for complaints management in consultation with the CNM for clinical concerns/complaints. There have been no DHB or HDC complaints lodged with the service since the last audit. Residents and family interviewed were aware of the complaints process.
Standard 1.1.9: Communication Service providers communicate	FA	There is a policy to guide staff on the process around open disclosure. Four residents and one family member (interviewed) confirmed the admission process and agreement was discussed with them and they were provided with adequate information on entry. Thirteen incident forms reviewed identified family were notified following a resident incident. The clinical nurse manager (CNM) confirmed family are kept informed of any change in resident's state of health as evidenced in progress notes. A family communication form is retained in each resident's file for

effectively with consumers and provide an environment conducive to effective communication.		the purpose of documented instances when families are kept informed. Two-monthly resident meetings are held and are open to family to attend. Two-monthly newsletters keep residents and family informed on all services provided and have included Covid updates. An electronic tablet is available for residents to skype with family and the service has a Facebook page to keep families informed. There is a newly launched website. Interpreter services would be available if required.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	The facility has been privately owned under current management for the last two and a half years. The facility manager/owner (non-clinical) and clinical nurse manager/registered nurse/owner are responsible for the daily management of the business. A third shareholder is the operations manager and fulltime cook. Coronation Lodge rest home provides care for up to 22 rest home level residents. There were 21 residents on the day of audit. One resident was on the long-term stay – chronic health conditions contract (LTS-CHC) and there were two respite care residents with one under ACC funding. All remaining 18 residents were under the Aged Residential Care Contract (ARCC). An additional eight boarders (under supported living) live in separate accommodation adjacent to the aged care facility. A 2021 business plan is being implemented that includes the service philosophy of care, quality goals and key performance indictors (clinical and non-clinical). This business plan is reviewed annually by the owners. Achievements to date include the implementation of an electronic resident records and quality management system (June 2020) through an aged care consultant. The service was awarded a compliance certificate from the DHB for gaining 100% implementation of advance care plans. Online training was commenced September 2021. The service received the Aged Advisor 2021 award for the best small rest home in the North Island. The owners engage the services of other professionals including accountants, human resources and health and safety consultant and aged care consultant. The owners are members of the Taranaki Chamber of Commerce. The facility manager has maintained eight hours of professional development over the past year relating to his respective role and responsibilities including education held at the DHB for advance care planning, infection control and Covid-19 and external health and safety course. The clinical nurse manager (CNM) is an experienced registered nurse (RN) and previously held the role of clinical nurse specialist for older people's health at Taranaki Base Hospital. She has completed clinical education including syringe driver training, interRAI competency, first aid and attends aged residential care study days as offered. The CNM has recently submitted her portfolio for senior nurse through the professional development recognition programme at the DHB. Both managers attend DHB forums and there are regular zoom meetings.
Standard 1.2.3:	FA	The quality and risk management plan and quality and risk policies describe Coronation Lodge's quality

Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.		improvement processes. The service contracts an aged care consultant who maintains and reviews policies to ensure they align with current good practice and meet legislative requirements. All policies are available on the intranet and hard copies are also available for all staff. Policy updates are received, and staff are required to read and sign. Quality management systems are linked to internal audits, incident and accident reporting, health and safety reporting, infection control data, surveys, and complaints management. Data that is collected is analysed and compared monthly and annually for a range of adverse event data (e.g., infections, skin tears, falls, bruises, medication errors). Corrective actions are documented, implemented where improvements are identified and are regularly evaluated. Benchmarking occurs through the electronic quality management systems. Information including identifying trends, analysis and graphs are shared with all staff as confirmed in staff meeting minutes and during staff interviews. Quality improvement projects are identified, implemented, and regularly evaluated for progress towards the goal for example falls reduction and polypharmacy. The internal audit programme schedule is set out by the contracted aged care consultant which monitors compliance against environmental, clinical and support services. Corrective actions are generated and completed for any audit outcomes less than 95%. There was evidence of re-audits as part of the corrective action plan with improvement in compliance. The outcomes and corrective actions are discussed at the head of department meeting/shareholders meeting held prior to the monthly staff meetings where results are discussed. An internal resident/relative survey was completed in June 2020 with all respondents satisfied or very satisfied. A meal survey completed November 2020 evidenced all residents were satisfied with the meals and food service. Survey results are fed back to participants. A risk management plan is in place. The owners hold a contractual relationship with an external company who assists them with implementation of health and safety processes. Health and safety policies have been provided and maintained by the contracted aged care consultant. There is a current online hazard register covering generic and specific hazards. The facility manager is the health and safety officer and has recently attended external health and safety training for initial health and safety representative training August 2021 and chemical safety training in May 2021. The health and safety officer is alerted electronically for any hazards/adverse events completed online though the quality management system. The physiotherapist completes safe manual handling sessions six monthly. Health and safety are an agenda topic at the staff meeting. The service provides a counselling service for staff and residents through the hospice counsellor and fortnightly chats/discussion with a church minister. Falls management strategies and the development of specific falls management plans are in place to meet the needs of individual residents who are at risk of falling. Strategies implemented have been successful in reducing falls. The service has been awarded a rating of continuous improvement for improvements in reducing falls.
Standard 1.2.4:	FA	There is an incident reporting policy that includes definitions and outlines responsibilities. Individual electronic

Adverse Event Reporting 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.		reports are completed for each incident/accident with RN assessment, investigation and follow-up including relative notification as evidenced on the incident/accident and in progress notes. Incident/accident data is linked to the organisation's quality and risk management programme. Thirteen incident/accident forms were reviewed (five falls, one laceration, one skin tear, two bruises and four medication errors – dropped medications). Neurological observations were conducted for residents with suspected head injuries. The facility manager and CNM reported that they are aware of their responsibility to notify relevant authorities in relation to essential notifications. A Section 31 notification and public health notification forms were completed in August 2021 for a suspected outbreak. A Section 31 was completed for one ACC respite care resident admitted with a stage three pressure injury.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	Human resources policies are in place to support recruitment practices. Five staff files reviewed (two caregivers, one communications officer, one caregiver/team leader and one cook/operations manager) contained evidence of signed employment agreements, reference checking and police vetting, orientation and education records and performance appraisals. The previous finding around documented references has been addressed. Performance appraisals are completed three months post-employment and annually thereafter. A current practising certificate was sighted for the CNM and other health professionals. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. All staff receive an induction employee handbook which includes health and safety and infection control. Staff receive specific orientation to their role. Staff interviewed believed new staff were adequately orientated to the service on employment. An annual training programme covering all the relevant requirements has been implemented for 2020 and in progress for 2021. Individual attendance records are maintained. There is an in-service topic each month in conjunction with the staff meeting. Inservice notes “lass notes” are available for staff unable to attend the session. External speakers have included Health and Disability, gerontology clinical nurse specialist, hospice, NZ wound society, age concern, physiotherapist, and infection control specialist – TDHB. During Covid restrictions zoom sessions were held. The service commenced Altura online training (video, questionnaire, and competencies) in September 2020. The staff complete a range of competencies relevant to their role including (but not limited to) health and safety, abuse/neglect, medication competencies, chemical safety, and a range of clinical skills. The CNM is interRAI competent. The CNM is a Careerforce assessor and verifier for level 3 and 4 and diversional therapy. There are 10 caregivers with four level 2 and one level 3.

Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. At the time of the audit, there were 21 residents living in the care facility. The facility manager and CNM work full-time Monday to Friday and on call after hours and weekends for both clinical and non-clinical matters. An agency RN is accessed 0700 to 100 to provide cover in the absence of the CNM. On the morning shift there is one full shift caregiver from 0700 – 1500 and one caregiver from 0700 – 1300 seven days a week. On the afternoon shift there is one full shift caregiver from 1500 – 2300 and one caregiver from 1530 – 2100 seven days a week. There is one caregiver on night shift with the CNM on call. The full shift caregivers/team leaders have first aid and are medication competent. There are separate cleaning/laundry staff rostered Monday – Friday. The CNM is a qualified diversional therapist (DT) and spends 1.5 hours per day coordinating and implementing the activity programme with the assistance of a communications officer from 0900 to 1330. The facility manager and operations manager share the maintenance role. The caregivers, residents and relative interviewed informed there are sufficient staff on duty at all times.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	The medication management policies and procedures comply with medication legislation and guidelines. Medicines are stored safely. The clinical nurse manager and senior caregivers (team leaders) who administer medications have completed medication competencies and medication education. Regular and 'as required' medications are delivered in robotic rolls and checked on delivery against the electronic medication chart. There were no self-medicating residents on the day of audit. The medication fridge and medication room temperatures are checked daily and within acceptable limits. All medications are prescribed and there are no standing orders. Nine electronic and one paper-based medication chart were reviewed and met prescribing requirements. All medication charts had photo identification and allergy status recorded. The outcomes of 'as required' medications were recorded in the electronic medication system and progress notes. Monthly audits are completed, and medication management discussed at staff meetings.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs	FA	All meals are prepared and cooked on site by a Monday to Friday cook and weekend cook. The kitchen is adjacent to the dining room and the main meal is at midday. The cooks are supported by caregivers during serving of meals and an afternoon kitchenhand serves the pre-prepared evening meal. There is a four-weekly seasonal menu which has been reviewed by a dietitian April 2020. The cook is informed of resident dietary preferences and notified of any changes to dietary requirements. Resident dislikes are known and accommodated. There are no special diets. The cook is notified of any dietary changes or weight loss and dietary interventions required. There is a current food control plan that expires 3 July 2022. Fridge, freezer, chiller temperatures, inward goods

are met where this service is a component of service delivery.		and end cooked temperatures are taken and recorded daily. All dry goods in the pantry were date labelled. Perishable food items in the fridge were date labelled. A cleaning schedule is maintained. Food services staff have completed food safety and hygiene training. Resident meetings and surveys allow the opportunity for resident feedback on the meals and food services generally. Residents and family member interviewed were very satisfied with the food and confirmed alternative food choices were offered for dislikes.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	The interRAI assessment process informs the development of the resident's care plan. Outcomes are reflected in the electronic care plan. The documented interventions describe the support required to meet the resident's goals and needs. Short-term care plans are reviewed regularly and either resolved or added to the long-term care plan if an ongoing problem. The previous finding around documented interventions in care plans has been addressed. Residents and family member interviewed reported that they are involved in the care planning and review process. Allied health professionals involved in the care of residents are included in the care plan.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	If a resident's condition changes the clinical nurse manager initiates a nurse specialist visit or GP consultation. Short-term care plans are developed on the electronic resident management system for resident changes to health. These guide caregivers for acute/short-term changes and progress against the goals are documented in progress notes and communicated at shift handover. The CNM reviews short-term care plans regularly. There was documented evidence of relative notification in the residents' files. One relative interviewed, confirmed they are notified of any changes to their relative's health. Staff have access to sufficient medical supplies (e.g., dressings). Sufficient continence products are available and resident files include a continence assessment and continence monitoring (as applicable) as part of the plan of care. Specialist continence advice is available as needed and this could be described. Wound assessments, regular evaluations and short-term care plans were in place for three residents with wounds (including one chronic wound, one lesion and one stage three community acquired sacral pressure injury). Photos demonstrate the healing or non-healing process. There have been regular GP reviews of wounds. The district nurses have been changing the pressure injury dressings and PICO vac. The clinical nurse manager has access to the wound nurse specialist at the DHB. Interviews with the clinical nurse manager and caregivers demonstrated an understanding of the individualised needs of residents. There was evidence of pressure injury prevention interventions, food and fluid monitoring, fluid balance, monitoring of bowels, monthly weights or more frequently as required, behaviour charts, neurological observations, blood sugar monitoring and blood pressure monitoring.

Standard 1.3.7: Planned Activities 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.	FA	The CNM qualified as a diversional therapist in January 2021 and develops and oversees the activity programme. She is actively involved for one and half hours per week day and at other times such as outings and one on one time. The DT is supported by the communications officer who is involved in implementing activities on the weekly planner. Caregivers' coordinate weekend activities. The programme is planned a month in advance and the weekly planner is displayed on the board in the dining room. The activity programme is planned around meaningful everyday activities and resident preferences including daily walks (indoor or outdoor), variety of daily exercises, newspaper reading, word games, floor games, gardening, mindful drawing, movies, hand massages foot spas, happy hour, and karaoke. Residents attend to the outdoor raised gardens. Community visitors include fortnightly entertainers, church visitors and pet therapy. Covid restrictions has disrupted community connections. There are visits into the community including age concern social mornings, Brookland Church meal and singing. The CNM/DT and facility manager take residents out to lunch monthly to such places as the golf club. There are daily drives to places of interest, shopping, and picnics. Festive occasions, international days and birthdays are celebrated. The younger person (LTS-CHC) enjoys daily rides and is encouraged to be as independent as possible. An activity profile is completed on admission in consultation with the resident/family (as appropriate). The activity plan in resident files reviewed reflected the specific requirements of each resident. The activity plan is evaluated six-monthly with family/resident and care staff input. The residents provide feedback on the programme through two monthly resident meetings and surveys. Activities were observed to be happening on both days of the audit.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	The clinical nurse manager evaluates all initial care plans for long-term residents within three weeks of admission. Files reviewed demonstrated that the long-term care plan was evaluated at least six monthly or earlier if there was a change in health status. The written evaluation identifies if the resident goals have been met or unmet and changes made to the care plan as required. The multidisciplinary review includes the clinical nurse manager, caregivers, DT, cook, resident and/or family member. There was at least a three-monthly review by the GP.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate,	FA	The facility has a current building warrant of fitness which expires 29 March 2022. The operations manager/cook and facility manager share the responsibility for daily and planned maintenance. Requests for repairs are entered into a maintenance book which is checked daily and signed off as completed (sighted). Essential contractors are available 24 hours. There is a weekly, monthly, and three-monthly planned maintenance schedule in place which includes internal, external, environmental and equipment checks and electrical testing of equipment. Random resident areas are checked monthly for hot water temperatures and records demonstrate temperatures are all below

accessible physical environment and facilities that are fit for their purpose.		45 degrees. There is safe access to communal areas for the residents and promotes independence for residents with mobility aids. The grounds and gardens are well maintained with outdoor shaded areas and raised garden beds. There is a designated outdoor smoking shelter. Caregivers interviewed stated they had sufficient equipment to carry out the cares for residents as outlined in the care plans. There are chair scales and a hoist available for resident falls.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator/CNM uses the information obtained through surveillance to determine infection control activities, resources, and education needs. Internal infection control audits and review of the infection control programme also assist the service in evaluating infection control needs. Infection control data is collated monthly, analysed for trends and corrective actions, and discussed at the monthly staff meeting. Benchmarking occurs through the aged care consultant electronic management system. Meeting minutes and graphs are available to staff. There is liaison and regular zoom meetings with the infection control team at the DHB providing support around Covid restrictions, pandemic, and outbreak management. There is sufficient personal protective equipment held on site. The service is operating under level 2 Covid restrictions with continued screening of visitors, limited visiting numbers and times and regular communication with residents and families. There were daily group texts from management keeping staff informed on Covid status. There was a suspected norovirus outbreak in August 2021. Contact and liaison with the Public Health department and notification to HealthCERT was sighted. Case logs were sighted. Stool specimen results were negative for norovirus.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	There is a restraint policy in place that states the service philosophy to restraint minimisation. The policy identifies that restraint is used as a last resort. The restraint coordinator is the CNM. On the day of audit, there was one resident using an enabler (bedrail). Verbal consent for enabler use had been signed by the activated enduring power of attorney. The safe use of the enabler is reviewed three-monthly with regular monitoring recorded. The service has been DHB approved for the use of a keypad exit at the main entrance due to the proximity of a main road and to maintain safety for individual residents as assessed. The code is visibly available to residents and staff were able to freely come and go as observed during the audit. There was one resident requiring environmental door restraint. All appropriate documentation had been completed for environmental restraint.

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.

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.2.3.9 Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include: (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk; (b) A process that addresses/treats the risks associated with service provision is developed and implemented.	CI	The service identified a quality improvement project around reduction of falls particularly for high risk/frequent fallers in 2019 following 130 falls for 2018. The service has been successful in reducing falls from 130 in 2018 to 41 in	A quality improvement plan was documented in February 2019 to reduce falls particularly for residents with conditions such as Parkinson’s with frequent falls. The action plan included falls risk assessments, communication with families and residents on falls prevention, physiotherapist six monthly safe manual handling sessions, falls prevention in-service for staff, suitable footwear, hip protectors, sensor mats, appropriate and safe mobility aids, non-slip socks, daily walks and exercises, two hourly toileting regimes, GP/geriatrician reviews, medication reviews, high falls risk care plans, uncluttered environment and administration of Vitamin D. The files of two frequent fallers were reviewed and there were detailed high falls risk care plans in place. Falls had reduced for both residents. There were 130 falls from February 2018 to February 2019; 88 falls from February 2019 to February 2020 and reduced further to 41 falls from February 2020 to February 2021.

		2021.	

End of the report.