

# Scovan Healthcare Limited - Taurima Rest Home

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## 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:

<b>Legal entity:</b>	Scovan Healthcare Limited
<b>Premises audited:</b>	Taurima Resthome
<b>Services audited:</b>	Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 25 November 2021    End date: 26 November 2021
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	29

# Executive summary of the audit

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## 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

Taurima Rest Home provides rest home level care for up to 30 residents. On the day of the audit there were 29 residents living at the facility including two boarders.

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, staff, and the nurse practitioner.

The facility manager is a registered nurse and has been in the role four years. The facility manager is appropriately qualified and experienced and is supported by an experienced clinical nurse leader and part-time registered nurse recently employed. Residents and family interviewed were very complimentary of the services they receive.

The previous certification audit shortfall around the quality system has been addressed.

There were no shortfalls identified at this audit.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Regular communication occurs with residents and relatives. Information about the services provided is readily available to residents and families/whānau. Complaints processes are implemented, and complaints and concerns are managed appropriately. Complaints/concerns forms are available.

## 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.
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Services are planned, coordinated, and are appropriate to the needs of the residents. Quality and risk management processes are established. Quality goals are documented for the service. A risk management programme is in place, which includes a risk management plan, incident and accident reporting, internal audits, meetings, surveys and health and safety processes. Adverse, unplanned, and untoward events are documented by staff.

An orientation programme and regular staff education and training are in place. There are adequate numbers of staff on duty to ensure residents are safe. A registered nurse is either on site or on call.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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The registered nurse takes responsibility for initial assessments, interRAI assessments completion of care plans and evaluations within the required timeframes. Care plans include supports and interventions to meet resident goals based on the interRAI outcomes and other assessments. Residents and relatives interviewed confirmed that they were involved in care plan review processes.

An activity officer coordinates a weekly activity programme that is varied and interesting and meets the abilities and preferences of the residents. Community activities have been restricted due to Covid. Residents enjoy twice weekly scenic drives.

Medicines are stored and managed appropriately in line with legislation and guidelines. The service uses an electronic medication system. Medication charts are reviewed by the general practitioners/nurse practitioner at least three-monthly.

Meals are prepared and cooked on site. The menu reflects resident preferences and has been reviewed by a dietitian. Individual dislikes and dietary needs are accommodated.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The building has a current warrant of fitness. All equipment is well maintained and on a planned schedule. There is adequate space for residents to move freely about the home using mobility aids. Communal areas are easily accessible. Outdoor areas are safe and accessible for the rest home residents. There is adequate equipment for the safe delivery of care.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint. Staff receive regular education and training on restraint minimisation. No restraint or enablers were in use.

## 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.
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The infection control programme is appropriate for the size and complexity of the service. The infection control nurse (registered nurse) is responsible for collating infection events, analysing and reporting of trends and corrective actions. Information is obtained through surveillance to determine infection control activities. There are additional resources, personal protective equipment and additional education provided in relation to Covid levels and restrictions. There have been no outbreaks.

## 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	16	0	0	0	0	0
Criteria	0	41	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
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints procedure is provided to residents and families during the resident's entry to the service. Access to complaints forms and suggestion box are located at reception. The facility manager is the privacy officer and responds and investigates complaints in consultation with the clinical nurse leader (one of the RNs employed by the service) and owner. Families and residents interviewed stated the facility manager and clinical nurse leader were very approachable should they have any concerns.</p> <p>A complaint register is maintained. There has been one complaint in 2020 and two complaints to date for 2021. Documentation evidenced that complaints received were managed in accordance with HDC guidelines. Timeframes for responding to each complaint were met and all three complaints reviewed were documented as resolved. The complaints and outcomes were discussed (as appropriate) at staff meetings. Managers and staff interviewed including the facility manager, clinical nurse leader, registered nurse (RN), two caregivers, one activity coordinator and one cook, understood their responsibilities in relation to reporting complaints.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively</p>	FA	<p>Three families and six residents interviewed confirmed they are kept informed of any health changes, including any events adversely affecting the resident. A contact with families form is completed on admission which indicates when the relative wishes to be contacted and for which accident/incident events. Ten accident/incident forms reviewed reflected documented evidence of families being informed following an adverse event. A communication sheet held in the resident's file also documents other discussions and notifications including GP</p>

<p>with consumers and provide an environment conducive to effective communication.</p>		<p>visits and changes in health status.</p> <p>Monthly resident meetings are held and open to family to attend. All areas of the service are discussed, and concerns addressed. Staff, residents, and family continue to be kept well informed on Covid levels and restrictions by frequent communication, newsletters, emails, and phone calls. Information is prominently displayed, and visitor screening continues. Currently there is restricted visiting. Families and residents interviewed stated they had been kept well informed during lockdown periods. They have access to the Taurima Facebook page which keeps families updated on all matters relating to the service. The staff and residents watch the TV 1 news briefs followed by general discussion. A resident advocate is available to residents and families and visits the facility regularly and as required.</p> <p>An interpreter service is available and accessible if required, through the district health board. Families and staff are utilised in the first instance.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Taurima Rest Home provides care for up to 30 residents at rest home level of care. At the time of the audit, there were 29 residents. Two residents were private boarders, and the remaining 29 residents were on the age residential - related care services (ARRC) contract.</p> <p>Taurima Rest Home is privately owned by two owner/directors (husband/wife team). They also own three other care facilities. The owners meet with the facility manager every three months (meeting minutes sighted). The facility manager provides a monthly report including progress towards business goals and clinical key performance indicators to the owner/directors. A 2021 business plan includes goals, objectives, and actions. Goals are regularly reviewed by the owners and facility manager. The rest home has maintained good occupancy, low infection rates and they are reducing falls with high falls risk action plans.</p> <p>The facility is managed by a full-time facility manager who is a registered nurse with a current practising certificate. She has been in the role for four years. She is supported by a long-serving experienced part-time registered nurse who is on site three days a week. A second part-time RN has been employed for two days a week who was a clinical manager at another facility. She also works one day a week at the company's other local facility. The RNs share the on-call RN roster.</p> <p>Both the facility manager and clinical nurse leader (one of the RNs) have attended DHB study days on infection control/Covid and an aged care study day. They also attended a company leadership conference with speakers on leadership, complaints management and behaviour management strategies.</p>
<p>Standard 1.2.3: Quality And Risk Management</p>	<p>FA</p>	<p>A quality and risk management system is established, which is understood by the facility manager, registered nurses, and staff. The facility manager is currently reviewing an aged care consultants' policy to ensure they meet the service requirements as policies will be available on the resident management intranet system being</p>

<p><b>Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>implemented post surveillance audit. New/reviewed policies and updates are discussed in staff meetings and staff are required to sign to declare they have read and understood the reviews/updates.</p> <p>Quality management systems are linked to internal audits, incident and accident reporting, infection control and health and safety reporting. The staff meetings are held monthly and include quality data analysis (health and safety, accidents/incidents, infection control) and trending, complaints/compliments and internal audits completed. The previous shortfall around documented evidence of infection control data analysis and recording complaints and corrective actions has been addressed.</p> <p>Data collected for a range of adverse events (e.g., skin tears, bruising, falls, medication errors) is collated and analysed and fed back to the owner/directors and staff. An internal audit programme is being implemented that covers all aspects of the service. Internal audit results and adverse event trends are discussed with staff as evidenced during interviews with staff and in staff meeting minutes. Where results are less than 95%, improvements are identified with corrective actions in place and a re-audit is scheduled. Corrective actions are signed off by the facility manager.</p> <p>Resident satisfaction surveys are completed annually with the last survey completed in September 2021. A quality improvement was identified around meals and discussions held with residents and food services staff. Residents interviewed during the audit were very complimentary of the meals. Survey results were shared with staff, residents, and families.</p> <p>The health and safety officer is the facility manager who has received health and safety training. Staff receive health and safety training, which begins during their induction to the service and ongoing as part of the annual education planner. Health and safety is included in the monthly staff meetings. Actual and potential risks are documented on the hazard register which is readily available to staff and last reviewed May 2020.</p> <p>In staff meetings, falls management strategies include sensor mats, intentional rounding, and reviewing residents at risk of falling. Hip protectors are being trialled for high falls risk residents. A falls clock posted in the staff room identifies times and location of falls. A high falls risk action plan is developed for residents who are at a greater risk of falling or frequent fallers.</p>
<p><b>Standard 1.2.4: Adverse Event Reporting</b></p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where</p>	<p>FA</p>	<p>The incident reporting policy includes definitions and outlines responsibilities. Individual reports are completed for each incident/accident with immediate action documented including any follow-up action(s) required. Incident/accident data is linked to the organisation's quality and risk management programme. A monthly summary of injuries includes an end of month analysis with actions taken.</p> <p>Ten accident/incident forms were reviewed (five unwitnessed falls, one skin tear, one dropped medication and three witnessed falls). Each event involving a resident reflected a clinical assessment and follow-up by a registered nurse. Neurological observations had been completed for 24 hours following unwitnessed falls.</p>

<p>appropriate their family/whānau of choice in an open manner.</p>		<p>The facility manager is aware of her responsibility to notify relevant authorities in relation to essential notifications. There has been one Section 31 completed (November 2021) for a fallen tree (on council land) that damaged the roof over two resident bedrooms requiring immediate repair. The event was managed safely.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Human resources policies are in place, including recruitment, selection, orientation and staff training and development. Five staff files reviewed (one RN, two caregivers, one activities officer and one cook) included evidence of the recruitment process, signed employment contracts, reference checking, signed job descriptions, and completed orientation programmes. The orientation programme provides new staff with relevant information for safe work practice. Staff interviewed stated that they believed new staff were adequately orientated to the service. Staff complete competencies relevant to their role such as medications, safe manual handling by the physiotherapist, chemical and food safety, hand hygiene and donning and doffing of personal protective equipment.</p> <p>A register of current practising certificates for the RNs and health professionals is maintained.</p> <p>There is an annual education schedule that has been completed as much as allowed due to Covid restrictions. Staff meetings precede in-services with good numbers of staff attending. Staff who are unable to attend are provided with meeting minutes and in-service notes. They are required to sign that they have read this information.</p> <p>There are 10 caregivers employed. One caregiver has Level 4 Careerforce qualification, two with level 3, three with level 2 and one with level 1. The facility manager is a Careerforce assessor and verifier. The three RNs are interRAI trained. The RNs have the opportunity to attend education and training offered at the DHB.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The staffing policy aligns with contractual requirements. There are two part-time RNs that cover Monday – Friday morning shifts and who are available afterhours on call. The facility manager/RN also does on call as required.</p> <p>There are adequate numbers of caregivers available. There is one on the long morning shift, one short shift (until 2.15 pm) and another caregiver on the short shift (until 10 am). On the afternoon shift there is a caregiver on the long afternoon shift and one on the short shift finishing at 9.30 pm. There is one caregiver on the night shift. Caregivers' complete laundry duties.</p> <p>There are designated cleaning and food services staff.</p> <p>Staffing is flexible to meet the acuity and needs of the residents. Interviews with residents and families confirmed staffing levels were satisfactory.</p>

<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. The RNs and senior caregivers who administer medications complete annual medication competencies and medication education. The facility manager/RN and clinical nurse leader have completed syringe driver training. All medications are stored safely. Medications (blister packs) are checked on delivery against the electronic medication chart and signed in by the RN. 'As required' medication packs are checked three-monthly for expiry dates. All medications were prescribed for a resident. There were no self-medicating residents on the day of audit.</p> <p>The medication cupboard is being monitored weekly for air temperature. The medication fridge monitoring is weekly. All temperatures were within the acceptable limits. Eye drops and creams in use had been dated on opening.</p> <p>Ten medication charts on the electronic medication system were reviewed. The medication charts met prescribing legislative requirements. 'As required' medications had indications for use. Medication charts had photo identification and allergy status documented. The GP/NP reviews the medication charts at least three-monthly.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>All meals and home baking are prepared and cooked on site by cooks seven days a week 6 am – 1.30 pm. They are supported by an afternoon kitchenhand 4.30 pm - 6.30 pm. The cook prepares and cooks meals as per the four-week rotating menu plan last reviewed by a dietitian November 2020. Resident preferences are reflected in the menu. The main meal is at midday and the kitchenhand heats and serves the pre-prepared evening meal. The cook receives a resident nutritional profile. Resident dislikes or food allergies are identified, and alternative foods offered. Diabetic desserts and soft diets are provided. The kitchen is adjacent to the dining room where meals are served from the servery.</p> <p>The food control plan has been verified and expires July 2022. The food control plan from is completed daily and includes temperatures for cooked foods, fridge, freezer, dishwasher (rinse and wash) and delivery of inward chilled goods. All food services staff have completed food safety and hygiene training. All perishable foods and dry goods were stored correctly, and date labelled. A cleaning schedule is maintained. The kitchen has been recently upgraded with new walls, doors, benches, flooring, and cupboards.</p> <p>Resident meetings include discussion around meals and suggestions. A food survey in June 2021 identified rating mostly of 3 (good) to 5 (very good). There has been a quality improvement plan implemented around evening meals identified in the resident annual survey. Residents interviewed were all very happy with the meals provided including the evening meals.</p>

<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>When a resident's condition alters, the RN initiates a review and if required, GP/NP or nurse specialist consultation. There is documented evidence on the family communication form that family members were notified of any changes to their relative's health including (but not limited to) accident/incidents, infections, GP visits, care plan reviews and changes in medications and appointments. Family members interviewed confirmed their relative's needs were being met.</p> <p>Adequate dressing supplies were sighted. Wound management policies and procedures are in place. A wound assessment and wound care plan/evaluations were in place for three chronic wounds and one skin lesion. The chronic wounds were linked to the long-term care plans. There were no pressure injuries on the day of audit. The GP/NP reviews wounds three monthly or earlier as required. The service has access to the DHB wound nurse specialist as required.</p> <p>Continence products are available. The residents' files include a urinary continence assessment, bowel management plan, and continence products used.</p> <p>Monitoring occurs for blood pressure, weight, vital signs, blood glucose, pain, challenging behaviours, food and fluid intake, positioning, and neurological observations. There are guides for caregivers for chest pain and low or high blood sugar levels.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The activity officer interviewed has been in the role five months. She is a level 4 caregiver and commenced the diversional therapy qualification. The activity officer works four days a week Wednesday to Saturday from 10 am to 4 pm and is supported by an activity assistant Sunday to Tuesday. The programme is planned in advance with the weekly programme being displayed. The activity officer makes daily contact with residents and reminds them of upcoming activities. Activities reflect resident preferences including newspaper reading/current affairs, exercises, walks, gardening, word games, bingo, bowls, arts and crafts, painting, nail therapy, happy hours, and movies. One-on-one time is spent with residents who choose not to participate in group activities.</p> <p>The residents previously enjoyed inter-home visits, community outings, Age Concern social days, church services and entertainment, however these have been restricted due to Covid. There are twice weekly scenic van drives. The van driver and activity officer have current first aid certificates. Events and festive occasions have been celebrated including mid-winter Christmas, Father's Day, Halloween, and Melbourne Cup.</p> <p>A "this is your life" profile is completed for each resident. The activity plan/social activity is included in the long-term care plan which is evaluated six-monthly. Progress notes are maintained.</p> <p>The service receives feedback on activities at the monthly resident meetings. Residents interviewed were satisfied with the activities and enjoy the outings. A resident-led gardening project is underway which will enable residents to have their own garden "patch".</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>All initial care plans reviewed were evaluated by the RNs within three weeks of admission and a long-term care plan developed. Care plans had been evaluated six-monthly for residents who had been at the service for six months or longer. Written evaluations identified if the desired goals had been met or unmet. There was a written record of the resident/relative review meeting. Input is sought from caregivers, GP/NP, and the activity officer. Short-term needs/support plan is developed for short-term problems. These are reviewed regularly and if an ongoing problem transferred to the long-term care plan. Ongoing nursing evaluations occur as indicated and are documented within the progress notes.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The facility has a current building warrant of fitness that expires 28 February 2022. A maintenance person is employed three hours a day for four days of the week to carry out maintenance and repairs and maintain gardens and grounds. Staff report repairs and requests on a breakdown form which is checked daily and signed off when repairs are completed. There are weekly, monthly, three-monthly, and six-monthly planned maintenance schedules in place. Planned maintenance includes checks on resident mobility aids, call bells, civil defence equipment and monthly resident hot water temperatures. All water temperatures in resident areas had been maintained below 45 degrees Celsius. Testing and tagging of electrical equipment has been completed annually and clinical equipment has been calibrated annually including the chair scales. Essential contractors are available 24 hours a day.</p> <p>There is safe and easy access to communal areas for the residents and promotes independence for residents with mobility aids. Resident rooms are refurbished as they become vacant. The grounds and gardens are well maintained and provide seating and shade.</p> <p>Caregivers interviewed stated they had sufficient equipment to carry out the cares for residents as outlined in the care plans. There are sensor mats, a standing hoist and sling hoist available for resident falls.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection</p>	FA	<p>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control nurse (clinical nurse leader) collates monthly individual infection data. Monthly infection control data is analysed for trends and quality improvements. Infection control data is discussed at management and staff meetings with graphs and monthly summary attached to meeting minutes which staff are required to read and sign. The GP/NP and the service monitors the use of antibiotics. Information is obtained through surveillance to determine infection control activities, resources, and education needs.</p> <p>The service has received ongoing support from the infection control team at the DHB including fortnightly zoom meetings, resource information and site visit. The facility manager and infection control nurse have attended infection control study days at the DHB and have competency in Covid swabbing. Isolation boxes have been set</p>

control programme.		<p>up for immediate use if required and staff interviewed were knowledgeable in the isolation procedure. There was sufficient personal protective equipment sighted and there are weekly stocktakes.</p> <p>All staff and all but two residents have received Covid vaccinations.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There are policies around restraint minimisation. There have been no residents using restraints or enablers since 2019. The clinical nurse leader is the designated restraint coordinator. There is an annual restraint meeting. All appropriate documentation is available if required. Staff receive training around restraint minimisation and managing challenging behaviours.</p>

## Specific results for criterion where corrective actions are required

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

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

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

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

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End of the report.