

# Brujen Investment Trust - Kenderdine Park

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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 The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

<b>Legal entity:</b>	Brujen Investment Trust
<b>Premises audited:</b>	Kenderdine Park
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 27 January 2021      End date: 27 January 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>	30

# 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

Kenderdine Park provides rest home and hospital level care for up to 35 residents. The service is operated by the Brujen Investment Trust. The facility is family owned, operated and managed by family members. Residents and families spoke positively about the care provided.

This surveillance audit was conducted against the Health and Disability Service Standards. The audit process included review of policies and procedures, review of residents' and staff files, observations, and interviews with residents, family/whānau, management, staff and a general practitioner.

There were no areas requiring improvement from the previous audit and no new requirements from 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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Effective communication to residents and their family members/friends occurs and interpreter service can be accessed as required.

A complaints register is maintained with complaints resolved promptly and effectively. There have been no complaint investigations by an external agency since the previous audit.

## 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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Brujen Holdings trading as Brujen Investment Trust is the governing body and is responsible for the services provided. A business plan documents a vision, direction and goals. Systems are in place for monitoring the services provided.

The owner/chief executive officer operates the business and a family member is in the position of facility manager. The facility manager is experienced and has been in the position for 14 years. The clinical nurse manager resigned the day before the audit and two senior registered nurses are in an acting capacity until the position is filled.

Quality and risk management systems are in place. There is an internal audit programme. Adverse events are documented on accident/incident forms. Quality data is being collated, analysed and evidenced corrective action plans are developed and implemented. Staff and resident meetings are held.

Policies and procedures on human resources management are in place and these processes are followed. An in-service education programme is provided and staff performance is monitored. Care staff are encouraged to complete the New Zealand Qualifications Authority unit standards.

There is a documented rationale for determining staffing levels and skill mixes to provide safe service delivery that is based on best practice. The acting clinical nurse managers/ registered nurses are on call after hours.

## 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 service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach to care delivery. There are policies in place to support assessment, planning, provision of care, evaluation and transfers for residents to safely meet the needs of the residents and contractual requirements. Residents have interRAI assessments completed and individualised care plans related to this programme. All care plans are evaluated at least six monthly.

The service provides planned activities meeting the needs of the residents as individuals and in group settings.

Medication policy identifies current best practice for medication management. Staff who administer medication have completed a medication competency in the last 12 months.

The onsite kitchen provides and caters for residents with food available 24 hours of the day and specific dietary likes and dislikes accommodated. The service has a four-week rotating menu which has been approved by a registered dietitian. Residents' nutritional requirements are met.

## 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 warrant of fitness is displayed at the main entrance to the facility. There have been no structural alterations since the previous audit.

## 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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The service has clear policies and procedures that meet the requirements of the restraint minimisation and safe practice standard. There were residents using enablers and no residents using restraints at the time of audit.

## 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 policy identifies current best practice for infection control management. Infections data are collated monthly by the clinical nurse manager.

## 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)
<b>Standards</b>	0	16	0	0	0	0	0
<b>Criteria</b>	0	39	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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 policy and associated forms meet the requirements of Right 10 of the Code. Information is provided to residents and families on admission and there is complaints information available at the main entrance. A complaint form is also provided to residents in a folder kept in each room. Residents and families stated that communication about anything they are concerned about is actioned immediately.</p> <p>Review of the register and interview of the CEO and FM evidenced three complaints have been received in the past 12 months. A fourth complaint logged concerned a complaint by the facility to the DHB relating to a new admission to the facility. Review of documentation evidenced complaints concerning the facility are managed well and the timeframes meet Right 10 of the Code.</p> <p>Staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p> <p>There have been no complaint investigations undertaken by external agencies since the previous audit.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with</p>	FA	<p>Residents and families interviewed stated they are kept well informed about any changes to their/their relative's status and outcomes of regular and any urgent medical reviews. The resident/family survey for 2020 and resident's files confirmed this. Staff understood the principles of open disclosure, which is supported by policy and procedures that meet the requirements of the Code of Health and Disability Services</p>



<p>consumers and provide an environment conducive to effective communication.</p>		<p>Consumers' Rights (the Code).</p> <p>Interpreter services can be accessed via the District Health Board (DHB) when required. The Chief executive officer (CEO) and facility manager (FM) advised residents' family members and staff act as interpreters, where appropriate. There is a wide range of different cultures both staff and residents who have English as their second language. Effective communication is managed well and an example of this was observed concerning a resident who does not speak English. In the resident's room is a comprehensive list of phrases in the resident's first language and the translation to English to help care staff communicate with this resident. Staff stated this works well.</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>Brujen Holdings trading as Brujen Investment Trust is responsible for the services provided. A business plan documents a philosophy, vision, direction and goals.</p> <p>The facility is managed by a FM who is an experienced manager and has been in the role for 14 years. The owner/CEO manages the business part of the service and the FM the day to day running of the service. The CEO stated they are on site at least twice a week and communicates with the FM at least daily. The CEO also fills in for the FM when the FM is absent. Annual meeting minutes of the senior management team were reviewed. The reviews and reports include but not limited to review of the years goals and objectives set out in the business plan, infection prevention and control, incident/accidents, clinical indicators, complaints and restraint.</p> <p>The clinical nurse manager (CNM) left employment the day before this audit giving management short notice between resigning and leaving employment. The CEO stated until a new CNM is employed which is expected to be within a short timeframe, two senior RNs have been appointed in an acting capacity. During the audit the CEO notified the appropriate person in the local DHB and HealthCERT of the CNM resignation and the temporary arrangements in place.</p> <p>The service's philosophy is in an understandable form and is available to residents and their family/representative or other services involved in referring residents to the service.</p> <p>The facility can provide accommodation for up to 35 residents. On the day of this audit there were 30 residents. Eleven hospital level and fifteen rest home residents are under the age-related residential care contract. One resident is under an individual client contract, two rest home and one hospital level residents are under a long-term chronic health contract. The service also holds a contract for respite care with the DHB and a residential care no-aged contract with the MoH.</p> <p>Thirty beds have been approved as dual purpose and five beds are designated rest home only.</p>

<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>The organisation has a quality and risk management system that guides the quality programme. Risk management activities are appropriate for the size and scope of the organisation. There was good evidence of the management of quality data. Quality data is collected, collated, analysed to identify any trends. Corrective action plans are developed in response to identified issues in a range of ways, including audits, incident/accident reports, complaints, surveys and deficits identified from meetings. Quality data is graphed month by month by the FM and is available for staff. Staff stated they discuss trends and corrective actions at the staff meetings and at handover. The FM demonstrated sound knowledge relating to quality and risk management.</p> <p>Satisfaction surveys for 2020 were reviewed and responses demonstrated a high level of satisfaction and were complementary of the care provided. Resident meetings minutes evidenced these are held on a regular basis. Quality and risk management issues are reported and discussed at management level and at the staff meetings. Review of the meeting minutes and interview of staff confirmed this.</p> <p>Policies and procedures are fully imbedded and are relevant to the scope and complexity of the service, reflected current accepted good practice and reference legislative requirements. Policies and procedures are reviewed at least yearly and were current. New / reviewed policies are available for staff to read and sign off once read. Staff confirmed the policies and procedures provided appropriate guidance for service delivery and they were advised of new policies / revised policies. Obsolete documents are archived.</p> <p>A risk register forms part of the quality plan and includes risks relating to both the organisation and the services.</p> <p>The health and safety policy covers all aspects of health and safety management. Actual and potential hazards are identified and documented in the hazard register. The register identifies hazards and showed the actions put in place to minimise or eliminate risks. Newly found hazards are communicated to staff. Hazards and safety issues are discussed at staff meetings. The CEO and FM demonstrated a sound knowledge of health and safety. Staff confirmed they understood and implemented documented hazard identification processes.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their</p>	<p>FA</p>	<p>Staff document adverse and near miss events on an incident/accident form. All forms are reviewed by the RN on duty and the family contacted as appropriate. The FM has overview of all completed forms. Incidents/accidents are investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated and analysed by the FM and trends shared with staff through staff meetings and handover. Graphs are generated and give good information for staff.</p> <p>The CEO and FM stated there have been no essential notifications to external agencies since the last audit apart from the change to the CNM position. Both the CEO and FM are aware of essential notification</p>

family/whānau of choice in an open manner.		reporting requirements.
<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>	FA	<p>Policies and procedures relating to human resources management are in place. Staff files include job descriptions which outline accountability, responsibilities and authority, employment agreements, references, completed orientation, competency assessments, police and visa vetting and training certificates.</p> <p>New staff are required to complete the induction programme. The programme is specific to the position. Staff are 'buddied' and supported by an experienced staff member. Staff performance is reviewed at the end of this period and yearly thereafter unless there are performance issues. Staff performance appraisals were current. Annual practising certificates were current for all staff and contractors who required them to practice.</p> <p>The education programme is the responsibility of the FM. Records are held for staff attendance at training sessions. In-service education is provided for staff and there was documented evidenced that this was provided at least monthly. During the Covid-19 lock downs training was interrupted and has since resumed. Clinical staff have attended the palliative care programmes. External educators provide some sessions and the RNs also undertake education sessions online provided by the local DHB. Staff have current first aid certificates. An electronic register records competencies, annual appraisals and practicing certificates.</p> <p>Medication competencies for staff responsible for medicine management were current and some health care assistants have a current 'second checker' competency for controlled drugs.</p> <p>The Careerforce education programme is also available for health care assistants (HCA) to complete and staff are encouraged to do so. Of the 13 health care assistants 10 have level 4 and three have level 3 attainment.</p> <p>Staff confirmed they have completed an induction, including competency assessments. Staff also confirmed their attendance at on-going in-service education and the currency of their performance appraisals.</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>	FA	<p>There is a documented rationale for determining staffing levels and skill mix to provide safe service delivery including acuity, skill mix of experienced staff and less experienced staff.</p> <p>Registered nurse cover is provided 24 hours, seven days a week. Rosters reviewed showed a four on four off rotation. The CEO advised staff who work short shifts or who are off duty are asked to work more hours if needed. The CEO reported they do not ever need to use bureau staff. The FM reported the rosters are adjusted to meet the changing needs of residents, resident acuity including occupancy and the environment.</p> <p>The FM works full time Monday to Friday. Two senior RNs are currently in an acting role until a new CNM is appointed. Six RNs are currently employed and have between seven months and three and half year's</p>

		<p>experience working in the aged care sector. Two of the six RNs are interRAI trained. Review of the rosters evidenced until a CNM is appointed, one RN and three HCAs are on the morning shift, one RN and two HCAs on the afternoon shift and one RN and one HCA on at night. The HCA pool is stable, and the majority of HCAs have been with the organisation for many years. The activities coordinator works Monday to Friday 8.30am to 3pm. The CEO/owner is on call for non-clinical matters. The acting CNMs are on call on the days they are rostered on duty.</p> <p>There are dedicated cleaning and laundry staff. The FM is responsible for general maintenance. The kitchen has two cooks and a kitchen hand.</p> <p>Residents, families and staff interviewed reported satisfaction with the staffing levels. Staff reported they are able to get through their work in a timely manner. Observations during the audit confirmed staffing levels are adequate.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided as required.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge were reviewed and were within the recommended range.</p> <p>Good prescribing practices noted included the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review was consistently recorded on the medicine chart.</p> <p>Standing orders are used and reviewed annually. This document was last approved and signed by the GP on the 12 May 2020. The registered nurse interviewed stated that prior to a standing order medication been administered a discussion is had with the GP who will then if appropriate prescribe the medication in the electronic medication system. Vaccines are not stored on site.</p>

		<p>There were no residents self-administering medications at the time of audit</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</p>
<p><b>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</b></p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The food service is provided on site and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Kenderdine Park was audited by the Ministry of Primary Industry on the 17 December 2020. The report identified two corrective actions to do with the visual cleanliness of the kitchen, At time of audit the kitchen was observed to be clean and the cleaning schedule was maintained</p> <p>Food temperatures, including for high-risk items, are monitored and recorded as part of the plan using an electronic database.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed, including cultural and spiritual food preferences. Any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. The kitchen provides two menu plans which support residents with specific culture food requirements. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was verified by resident and families/whānau interviews, satisfaction surveys and residents' meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p>
<p><b>Standard 1.3.6: Service Delivery/Interventions</b></p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP reported that he is available after hours and when contacted by staff, information is provided in a way that identifies that Kenderdine Park is providing a 'comprehensive level of care. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.</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 activities programme is provided by an activities co-ordinator who supports the residents Monday to Friday 8.30 am to 3.00 pm. Residents are supported by activities that are easily assessed by staff throughout the weekend.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities, and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated daily and as part of the formal six-monthly care plan review.</p> <p>Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. There are three lounge areas as well as individuals' bedrooms where residents have the option of watching TV in their own language. The activities calendar emphasises and highlights residents' cultural beliefs and celebrations that occur regularly at Kenderdine Park.</p> <p>Residents and families/whanau are involved in evaluating and improving the programme through day-to-day discussions with residents and resident meetings. Residents interviewed confirmed they find the programme interactive and interesting.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short-term care plans being consistently reviewed, and progress evaluated as clinically indicated were noted for infections, wounds and post-surgery. When necessary, and for ongoing problems, long term care plans are added to and updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided</p>	<p>FA</p>	<p>A current building warrant of fitness is displayed at the main entrance to the facility that expires on the 30 November 2021. There have been no structural alterations since the last audit.</p>

with an appropriate, accessible physical environment and facilities that are fit for their purpose.		
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Surveillance is appropriate to that recommended for long term care facilities and includes urinary tract infection, respiratory tract infection, skin, wound, eye, gastro enteritis and other infections. The IPC coordinator reviews and all reported infections, and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs and short-term care plans are developed.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Trends are identified from the past year and this is reported by the clinical nurse manager and reported to the facility manager and owner.</p> <p>The facility has had a total of 26 infections reported for 2020. Residents' files reviewed highlighted short term and long-term care planning to reduce and minimise the risk of infection. Health care assistants interviewed demonstrated knowledge of residents who have a higher risk of infections and the interventions required.</p> <p>Infection control measures recommended by the ministry of health for the management of COVID-19 pandemic were implemented. Learnings from the Covid-19 pandemic have been incorporated into practice, with additional staff education implemented. There has been no infection outbreak reported since the last audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The restraint minimisation and safe practice policy includes a definition, assessment and evaluation details and complies with the requirements of the standard. The service has a restraint free philosophy. There were three residents using an enabler at the time of audit. Equipment is used, such as low beds so that restraint is not required. Staff interviewed demonstrated sound knowledge of the difference between a restraint and an enabler and the process should a resident request an enabler. Staff have received on-going education relating to challenging behaviours, enablers and restraint.</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.