

# Anglican-Methodist South Canterbury Glenwood HomeTrust Board - Glenwood 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>	Anglican-Methodist South Canterbury Glenwood Home Trust Board
<b>Premises audited:</b>	Glenwood Home
<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: 13 April 2021    End date: 14 April 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>	42



# 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

The Anglican-Methodist South Canterbury Glenwood Home Trust Board owns and operates Glenwood Home. The service provides care for up to 42 residents with full occupancy on the days of audit.

This unannounced surveillance audit was conducted against the Health and Disability Standards and the contract with the district health board. The audit process included observations and interviews with residents, family, management, a general practitioner and staff, and a review of resident and staff files.

Glenwood has an established quality and risk management system. Residents, families and the GP interviewed, commented positively on the standard of care and services provided at Glenwood. There are well developed systems that are structured to provide appropriate quality care for residents.

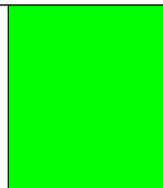
The facility manager has health management experience in a public hospital setting. The board meets monthly, and the management team provides reports to the board regarding all aspects of service provision.

This audit has identified one area requiring improvement relating to the controlled drug medication register.

Glenwood continues to exceed the required standard around surveillance of infections.

## 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.

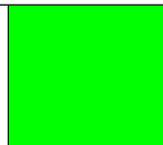


Standards applicable to this service fully attained.

Residents and family members confirmed that open communication is practiced. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service. Complaints are documented and maintained in a complaints' register.

## 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.

Glenwood has established and well-maintained quality and risk management processes showing high compliance. Adverse events are managed and recorded by the staff and clinical assessments and care is provided by registered nurses. Human resource management policies are implemented. Competencies and practicing certificates are up to date and documented in a register. The service has an internal training programme which includes a wide range of topics. 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.		Some standards applicable to this service partially attained and of low risk.
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The clinical manager and registered nurses assess and review residents' needs, outcomes and goals with the resident and/or family input. Care plans viewed demonstrated service integration and are reviewed at least six-monthly. Resident files include medical notes by the contracted GP and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and senior caregivers are responsible for the administration of medicines. Medication charts are reviewed three-monthly by the GP.

The activities coordinator implements the activity programme to meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings, and celebrations.

All meals are cooked on site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated. Residents were very satisfied with the meals.

## 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 holds a current warrant of fitness and regular scheduled maintenance is carried out.

## 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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Glenwood maintains a restraint free environment. Restraint minimisation is practiced and overseen by the clinical manager. There are no residents using enablers or restraints.

## 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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Infection surveillance data is collected and analysed monthly to identify areas for improvement or corrective action requirements. Trends are identified, and quality initiatives are discussed at staff meetings. Glenwood has maintained low rates of urinary tract infections over the past two years.

## 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	15	0	1	0	0	0
<b>Criteria</b>	1	39	0	1	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<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 facility manager has overall responsibility for ensuring all complaints (verbal or written) are fully documented and investigated. There is a complaint register that included relevant information regarding the complaint. Complaints were reported monthly to staff via the various meetings and the board on a monthly basis. There were five complaints received in 2020 and one in 2021 - year to date. All of the complaint documentation included follow-up letters, and resolutions were completed within the required timeframes. A complaints procedure is provided to residents within the information pack at entry. Feedback forms are available for residents and relatives in various places around the facility.</p> <p>The service has responded to a complaint received via the Health and Disability Commissioners office in September 2020. The service has provided information and documentation in relation to the complaint. The complaint process remains open, with further and additional information and response currently being prepared for the HDC office.</p> <p>Staff interviewed were able to discuss the complaints process.</p>
<p>Standard 1.1.9: Communication Service providers</p>	FA	<p>A specific policy to guide staff on the process to ensure full and frank open disclosure is available. Full information is provided at entry to residents and family/relatives. The information pack is available in large print and advised that this can be read to residents. Families are involved in the initial care planning and in ongoing</p>

<p>communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>care.</p> <p>Management promotes an open-door policy. Four residents (one hospital, two rest home and one rest home/mental health) and three family members (two hospital and one rest home) interviewed confirmed that the staff and managers are approachable and available. Residents and family are informed prior to entry of the scope of services and any items that are not covered by the agreement.</p> <p>Regular contact is maintained with family including if there is an incident/accident, a care or medical issue or a complaint arises. Twelve incident forms reviewed identified that family were notified following a resident incident unless specified not to be notified for minor incidences or on the resident request. Interpreters are available as required.</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>The Anglican-Methodist South Canterbury Glenwood Home Trust Board owns and operates Glenwood Home. The service provides care for up to 42 residents within 29 dual-purpose beds and 13 rest home beds. On the day of audit, there were 13 rest home residents (including two residents under mental health contracts) and 29 hospital care residents (including four on mental health contracts and one bariatric care). All other residents were under the age-related residential care services agreement. There were no residents on Palliative care contracts or on respite.</p> <p>The facility manager has a background of speech and language therapy and health management experience in a public hospital setting and has been in the role for five years. The clinical manager has been in the role for six years and has a background in aged care and mental health.</p> <p>Glenwood has a business plan, which is reviewed annually. The board and management team have developed a strategic plan for 2021 - 2024. The board meets monthly, and the management team provides a report to the board regarding all aspects of service provision. The Board completes a Health and Safety walk-through prior to the board meetings.</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</p>	<p>FA</p>	<p>Policies and procedures are implemented, and this provides assurance that the service is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001.</p> <p>Glenwood continues to implement their internal audit programme that includes all aspects of clinical care. Issues arising from internal audits are developed into corrective action plans. Monthly and annual analysis of results are completed and provided to staff, consumers and the board.</p> <p>Facility meetings held include quality and health and safety, full staff meetings, kitchen meetings, resident and relative meetings, diversional therapy and cleaners' meetings. Meeting minutes sighted evidenced that there is</p>

<p>continuous quality improvement principles.</p>		<p>discussion around quality data including complaints, compliments, health and safety, accident/incident, infection control, internal audits and survey results. The staff interviewed were aware of quality data results, trends and corrective actions.</p> <p>Falls prevention strategies are in place.</p> <p>The health and safety committee meets three-monthly. All incident and accidents are reported to the Board at their monthly meetings and an annual report is prepared after the annual health and safety audit at year's end. Health and safety policies are aligned with the current legislation and the service continues to be led by an experienced health and safety officer.</p> <p>Annual resident/relative satisfaction surveys continue to be completed with results communicated to residents and staff. The overall satisfaction result for the resident/relative satisfaction survey completed for 2020 was 91%. Results of surveys are communicated to staff via staff meetings. Corrective actions were undertaken with regards to food service and the dining experience.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>A sample of 12 accident and incident forms from January 2021 – March 2021 were reviewed. Accidents and incidents are recorded on electronic records. All accident/incident forms document RN review and follow-up within a timely manner. There is documented evidence that the family/next of kin had been notified promptly of accidents and incidents.</p> <p>There is evidence of assessment and first aid provided, registered nurse follow-up including clinical observations, review by GP and referral as appropriate. The development of short-term care plans as a result of an accident/incident was consistently evident in paper-based files.</p> <p>Staff interviewed confirmed that incident and accident data are discussed, and information is made available.</p> <p>No situations that require essential reporting have been experienced. The service is aware of the need to notify relevant authorities as required.</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</p>	<p>FA</p>	<p>There are human resources policies to support recruitment and retention of staff. Five staff files sampled (two RNs, a cook, and two healthcare assistants) contained all relevant employment documentation. Position descriptions outline accountability, responsibilities and authority. Staff files are internally audited to ensure full compliance.</p> <p>Current practicing certificates were sighted for the RNs, and allied health professionals. Performance appraisals were up to date. Current performance appraisals demonstrate an evaluation of staff performance and competence.</p>

<p>requirements of legislation.</p>		<p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice and covers the essential components of the services provided. Staff interviewed believed that new staff were adequately orientated to the service on employment.</p> <p>Careerforce assessments and qualifications are facilitated by the Clinical Manager and staff are encouraged to progress through the various levels.</p> <p>The education planner in place covers the compulsory education requirements as well as additional clinical in-service and external education. Two RNs including the clinical manager, have completed interRAI training. Staff completed competencies relevant to their role. The service has commenced full day training sessions for all staff which will be run four times per year. The training day topics include health and safety, managing challenging behaviours, code of rights, manual handling, infection prevention, continence, care planning, palliative care, nutrition, cultural safety and chemical safety.</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>Glenwood 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 including management of dual service beds.</p> <p>The clinical manager and an RN provide on call cover including weekends. There is an RN on duty 24 hours a day. There are seven HCAs on morning and six HCAs on afternoon shifts including long and short shifts. There are two HCAs and a registered nurse on night shift.</p> <p>Three HCAs and one RN interviewed confirmed that they have appropriate staffing numbers and skill mix on their shifts. They confirmed that staff sickness and vacant shifts were covered. Review of the roster showed that staffing hours were extended to support increased acuity at times. The clinical manager advised that in addition to the registered nurse on the floor, an additional registered nurse shift is available for paper days and to support the clinical manager and clinical team.</p> <p>Residents and relatives interviewed stated that there were sufficient staff on duty at all times. Staff stated that they feel supported by RNs, and the management team.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current</p>	<p>PA Low</p>	<p>Ten electronic medication charts were reviewed and included seven hospital and three rest home. The medication management policies and procedures comply with medication legislation and guidelines. There is one central treatment room. Medication fridge and medication room temperatures are checked daily and recorded weekly. Controlled drug medication is stored appropriately however, weekly checks of medications have not been conducted. Medicines are appropriately stored, and all expiry dates were in accordance with relevant guidelines and legislation. Medication administration practices complied with the medication management policy on the</p>

<p>legislative requirements and safe practice guidelines.</p>		<p>medication rounds observed. Medication prescribed is signed as administered on the electronic chart.</p> <p>Registered nurses and senior HCAs administer medicines. All staff that administer medicines are competent and have received medication management training. The facility uses a blister packed medication management system for the packaging of all tablets. The clinical care manager and senior RN reconcile the delivery of medications and documents this. All medication charts reviewed aligned with prescribing requirements. There was evidence of three-monthly medication reviews by the GP. All medication charts have photo identification. Allergies or nil known allergies were recorded. There were no residents self-administering their own medicines. Standing orders are not in use.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The service employs a morning cook from 7 am to 1.30 pm and an afternoon cook from 3.30 pm to 7 pm. There is a kitchenhand on each morning shift. All kitchen staff have current food safety certificates. The head cook oversees the procurement of the food and management of the kitchen. There is a well-equipped kitchen, and all meals are cooked on site. Meals are served directly from bain maries from the kitchen to the dining room. Meals going to rooms on trays have covers to keep the food warm. Special equipment such as lipped plates are available. On the day of audit, meals were observed to be hot and well-presented, and residents stated that they were enjoying their meal.</p> <p>There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. A verified food control plan is implemented with an expiry date of August 2021. Internal audits are implemented to monitor performance. Kitchen fridge and freezer temperatures were monitored and recorded daily. Food temperatures are checked, and these were all within safe limits. The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. This is reviewed six-monthly as part of the care plan review. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes were noted on a whiteboard. The four-weekly menu cycle is approved by a contracted dietitian. All residents and family members interviewed were very satisfied with the 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</p>	<p>FA</p>	<p>When a resident's condition changes, the RN will initiate a GP consultation. On interview, a GP confirmed that care provided is of a high standard, and GPs are kept informed. Staff stated that they notify family members about any changes in their relative's health status. All five care plans sampled, have interventions documented. Care plans have been updated as residents' needs changed.</p> <p>HCAs stated that there are adequate clinical supplies and equipment provided, including continence and wound care supplies and these were sighted.</p> <p>Wound assessment, wound management and evaluation forms are in place for all wounds. All wounds are</p>

<p>desired outcomes.</p>		<p>documented on individual electronic wound management plans and include a comprehensive assessment, management plan, photographic progress and evaluations. Wound monitoring occurred as planned. There was a total of 16 wounds involving nine residents. Wounds included six skin tears, two surgical wounds, two venous ulcers, four skin lesions, one other and one grade 2 pressure injury. On interview the RNs advised the wound care specialist is contacted for advice as required. All wounds are being managed according to management plans and healing.</p> <p>Monitoring forms are in use as applicable, such as weight, vital signs and wounds. Resident falls are reported on accident forms and written in the progress notes. Neurological observations are completed for unwitnessed falls or falls where residents hit their heads. Family is notified. Behaviour charts are available for any resident that exhibits challenging behaviours.</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>Two qualified diversional therapists together provide a programme over seven days a week. Both staff work on one afternoon per week to facilitate time for planning and meetings. A group of volunteers known as the friends of Glenwood come and assist with happy hour, scrabble and craft activities. On the days of audit, residents were observed going for walks, listening to music and playing games. There is a comprehensive volunteers' orientation package completed by all volunteers.</p> <p>The activities programme is developed monthly, and all residents receive a monthly and updated weekly programme. The programme is also available on communal noticeboards. Residents have the choice of a variety of activities in which to participate, and every effort is made to ensure that activities are meaningful and tailored to residents' needs. These include exercises, games, quizzes, music, walks outside and regular outings. Staff and volunteers drive the van. Residents interviewed described weekly van outings, musical entertainment and attendance at a variety of community events.</p> <p>Those residents who prefer to stay in their room or who need individual attention have one-on-one visits to check if there is anything they need and to have a chat. The activities staff maintain a register and are aware of each resident's needs, and plan activities based on assessed needs.</p> <p>There is a Methodist and Presbyterian Church service held in the facility monthly. A catholic communion service is scheduled routinely. There are van outings weekly. There are regular entertainers visiting the facility. Special events like birthdays, Easter, Fathers' Day, Anzac Day and Chinese New Year are celebrated.</p> <p>Younger residents have individualised programmes which cater for their specific needs including (but not limited to) shopping outings, visits to the races, BBQ meals and assistance to access and attend local groups such as a woodworking group.</p> <p>Residents have an activity assessment completed over the first few weeks following admission that describes the residents past hobbies and present interests, career and family. Resident files reviewed identified that the activity plan is based on this assessment. Activity plans are evaluated at least six-monthly at the same time as the</p>

		review of the long-term care plan. Resident meetings are held monthly.
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The long-term care plans reviewed (apart from the new admission) had been evaluated by the RNs six monthly or when changes to care occurs. Short-term care plans for short-term needs are evaluated and signed off as resolved or added to the long-term care plan as an ongoing problem. Activities plans are incorporated in the long-term care plan and these are also evaluated six-monthly. The multidisciplinary review involves the RN, GP and resident/family if they wish to attend. There are three monthly reviews by the GP for all residents. The family members interviewed confirmed that they are informed of any changes to the care plan.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building holds a current warrant of fitness which expires 1 May 2021. A maintenance officer works 12 hours per week and is available after hours as required. There is a preventative and reactive maintenance programme. External contractors are used when required. The gardener is contracted.</p> <p>Electrical equipment has been tested and tagged. There are scales suitable for all resident needs available. Hot water temperatures have been monitored randomly in resident areas and were within the acceptable range. There is a mixture of carpet and vinyl flooring throughout the facility. The utility areas such as the kitchen and laundry have vinyl flooring. Ensuites, toilets and communal showers and toilets have nonslip vinyl flooring. There is an internal lift providing access between the two floors. All corridors have safety rails and promote safe mobility with the use of mobility aids. The facility has recently completed renovations including expansion and enhancement of the dining room. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens were well maintained. There are courtyard areas with seating and shade provided. There is safe access to all communal areas.</p> <p>Care staff interviewed stated they have adequate equipment to safely deliver cares for all levels of care.</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>There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place appropriate to the complexity of service provided. Any resident who is suspected of having an infection is reviewed by an RN and the general practitioner. Specimens are taken as appropriate and sent to the laboratory and a record of this action is maintained in the resident's clinical record. Results are received, considered and documented. The surveillance data is collected and analysed monthly to identify areas for improvement or corrective action requirements. Trends are identified, and quality initiatives are discussed at staff meetings (minutes sighted). Glenwood has continued to maintain low rates of urinary tract infections. The GP reviews antibiotic use at least three-monthly with the medication review. Systems are in place that are appropriate to the size and complexity of the facility.</p>

control programme.		Quality improvement initiatives are undertaken and recorded and have resulted in continued improved outcomes for residents to a level that continues to exceed the required criteria around infection control surveillance.
Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised.	FA	Glenwood provides a restraint free environment. The clinical manager oversees the restraint process within the facility. There are policies and education provided relating to restraint, enablers and the management of residents who may exhibit behaviours that challenge. The service remains restraint-free, and no enablers are in use. There is a restraint policy that guides staff should restraint be required.

## Specific results for criterion where corrective actions are required

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

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	PA Low	The storage of medications complies with recommended guidelines and legislation. The one storage room which houses medications and medication trollies when not in use is locked at all times. The medication room and medication fridge are monitored, and temperatures are recorded weekly. Controlled drug medication is stored securely. On review, the controlled drug register has been completed correctly at each entry and six-monthly stocktakes have been conducted. Weekly reviews of stock checks have been recorded infrequently over the past six months.	The controlled drug register has not had consistent weekly checks recorded.	<p>Ensure that weekly controlled drug register checks are conducted and recorded.</p> <p>60 days</p>

## 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, 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
<p>Criterion 3.5.7</p> <p>Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.</p>	CI	<p>The surveillance data is collected and analysed monthly to identify areas for improvement or corrective action requirements.</p> <p>Glenwood developed an infection control goal around reduction of UTI by promoting hydration in 2018. Ongoing staff training, and monitoring have resulted in continued improvement with low rates of urinary tract infections during 2019 and 2020.</p>	<p>A project commenced in 2017 to reduce incidence of urinary tract infections in residents has been continued. The clinical manager and RNs have continued to monitor staff's IC practices and compliance around scheduled and opportunistic hydration rounds. Further education and training around infection control, continence and hand hygiene has been completed. The rate of urinary tract infections has been monitored throughout 2019, 2020 and 2021. The number of UTIs recorded in 2019 was 28 and in 2020 was 23. These numbers remain low in terms of per 1000 occupied bed days. For year to date (2021) three UTIs have been recorded.</p>

End of the report.