

Goodwood Park Health Limited - Seadrome Home and Hospital

Introduction

This report records the results of a Certification 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 Q-Audit 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:

Legal entity: Goodwood Park Health Limited

Premises audited: Goodwood Seadrome Ltd

Services audited: Hospital services - Geriatric services (excl. psychogeriatric); Dementia care

Dates of audit: Start date: 4 September 2019 End date: 5 September 2019

Proposed changes to current services (if any): To provide hospital (medical) services for residents requiring long term support chronic health conditions (LTSCH).

Total beds occupied across all premises included in the audit on the first day of the audit: 43

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

Indicator	Description	Definition
Yellow	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
Red	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

Seadrome Home and Hospital provides rest home and dementia levels of care for up to 45 residents. The service is owned by Goodwood Park Health Limited. The service is managed by a suitably qualified facility manager who is supported by a general manager (GM), nurse consultant (NC), quality coordinator (QC) and charge nurses (CNs). There have been no significant changes to the facility or services since the last audit. Residents and family/whanau spoke positively about the care provided.

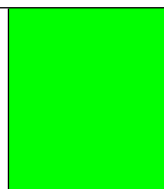
This certification audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board (DHB) and this includes being assessed to provide medical services. This audit found the provider was prepared to provide hospital medical services. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, families, management, staff and a nurse practitioner (NP).

Previous improvements required in relating to advance directives/resuscitation orders, the quality programme, medicine management, first aid and interRAI assessments have been addressed and maintained.

There are six areas requiring improvement relating to orientation of new staff, annual performance appraisals, documenting of progress notes by the nursing staff, completion of long-term care plans within the required time frames, documenting wound dimensions and regular inspection of fire extinguishers.

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.

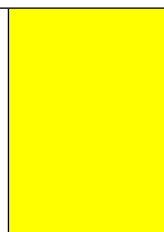
Residents and families are provided with information about the Health and Disability Commissioners Code of Health and Disability Services Consumer Rights' (the Code) and these are respected. Services provided support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner.

Open communication between staff, residents and families is promoted, and was confirmed to be effective. There are systems in place to ensure residents and family/whanau are provided with appropriate information to assist them to make informed choices on behalf of the residents. The residents' cultural, spiritual and individual values and beliefs are assessed and acknowledged. There is no evidence of abuse, neglect or discrimination. The service has linkages with a range of specialist health care providers to support best practice and meet resident's needs.

The complaints process is accessible and meets consumer rights legislation.

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.



Some standards applicable to this service partially attained and of low risk.

Business and quality and risk management plans include the risks. The business plan includes scope, direction, goals, values and mission statement of the organisation. Monitoring of the services by the governing body is regular and effective. An experienced and suitably qualified person manages the facility.

The quality and risk management system include collection and analysis of quality improvement data, identifies trends and leads to improvement. Staff are involved in quality and risk management, and feedback is sought from residents and families. Adverse events are documented, and corrective actions implemented. Actual and potential risks, including health and safety risks are identified in the risk management plan. Policies and procedures support service delivery and are current and reviewed regularly.

Systems are in place for the recruitment and employment of staff. Staff are encouraged to complete the appropriate foundation education and support is provided to attend monthly training. Staff rosters reflect the specific support required for residents.

Consumer information management systems meet the required standards. Archived records are stored securely, and all resident information is integrated and readily identifiable using relevant and up to date information.

Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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There is an admission package available prior to or on entry to the service. Registered nurses (RNs) are responsible for each stage of service provision. Nursing staff review each resident's needs, outcomes and care plan goals at least six monthly.

Resident files include medical notes by the nurse practitioner (NP), nursing team and visiting allied health professionals' documentation.

Medication policies reflect legislative requirements and guidelines. Registered nurses and medication competent care staff responsible for administration of medication complete annual education and medication competencies. The medicine charts had been reviewed by the nurse practitioner at least three monthly.

An occupational therapist and diversional therapist (DT) implement activities in the dementia care unit and hospital and health care assistants include activities as part of their role. The programme includes community visitors, music therapy and Maori Te Wa hui. Interviews with family / whanau expressed satisfaction with the activities programme in place.

Residents' food preferences and dietary requirements are identified at admission. All meals and baking are cooked on site by a kitchen staff employed by Seadrome. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines. There are nutritious snacks available 24 hours a day.

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.		Some standards applicable to this service partially attained and of low risk.
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There is a current building warrant of fitness which expires 3rd September 2020. Equipment and electrical checks are conducted. Fixtures, fittings, floor and wall surfaces are made of accepted materials for this environment. There is evidence of ongoing renovations and re-painting. Resident rooms are of an appropriate size to allow for care to be provided and for the safe use and manoeuvring of mobility aids. The dementia area is secure with large, safe areas for residents to wander.

Cleaning and laundry services are of an acceptable level. Cleaning and laundry services are monitored to ensure they continue to meet the needs of the residents.

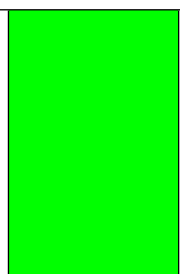
Essential emergency and security systems are in place. There is an approved fire evacuation plan and emergency drills are conducted as required. Call bells allow residents to access help when needed.

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 RN is the restraint coordinator. The organisation has policies and procedures that support the minimisation of restraint. Ongoing restraint and challenging behaviour training are provided. There were no residents using restraint and there was one using an enabler at the time of the audit. The dementia area is secure. There is keypad entry to the grounds which enables visitors to come and go as they please.

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 prevention and control management system are in place to minimise the risk of infection to residents, visitors and other service providers. The infection control coordinator is responsible for coordinating education and training of staff. The required policies and procedures are documented. Infection data is collated monthly, analysed and reported during staff meetings. The infection control surveillance and associated activities are appropriate for the size and complexity of the service.

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	41	0	3	1	0	0
Criteria	0	87	0	4	2	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 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Seadrome Home and Hospital has policies and procedures to meet their obligation in relation to the Code of Health and Disability Services Consumer Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff and ongoing training as verified in the training records.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files sampled show that informed consent has been gained appropriately using the organisation's standard consent form. These are signed by the enduring power of attorney (EPOA) and the general practitioner makes a clinically based decision on resuscitation authorisation. Staff were observed to gain consent for day to day care. Interviews with relatives confirmed the service actively involves them in decisions that affect their family members' lives.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>As part of the admission process residents and family/whanau are given a copy of the Code, which includes information on advocacy services. Posters and brochures related to the national advocacy service were displayed and available in the facility. Family members were aware of the advocacy service, how to access this and their right to have support persons. The facility manager and staff provided examples of the involvement of advocacy services in relation to residents' care.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment. The facility has unrestricted visiting hours and encourages visits from residents' family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their encounters with staff.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The complaints policy and associated forms meet the requirements of the Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to make a complaint. The service aims to acknowledge complaints and report outcomes in a timely manner. If more time is needed reason for delay is noted.</p> <p>The complaints register reviewed showed that complaints have been received over the previous years and actions were taken through to an agreed resolution, are documented and completed in a timely manner. Action plans reviewed confirmed required follow up and improvements have been made where possible. The FM is responsible for complaints management and follow up and advised there have been no complaint investigations by the Ministry of Health (MOH), Health and Disability Commission (HDC), Police, Accident Compensation Corporation (ACC) or Coroner since the previous audit at the facility. All staff and family/whanau interviewed confirmed a sound understanding of the complaints process and actions that are required. No complaints have been received since the previous audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>Information about the consumer rights legislation, advocacy services and the complaints process are provided on admission and displayed at the reception. The Code is available in Maori and English. Family members interviewed were aware of consumers rights and confirmed that information was provided to them during the admission process.</p> <p>The information pack outlines the services provided. Resident agreements signed by an enduring</p>

		power of attorney (EPOA) were sighted in records sampled. Service agreements meet the district health board requirements.
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>The residents' privacy and dignity are respected. Staff were observed maintaining privacy. There are shared bedrooms in the dementia wing and consent was obtained from the EPOAs. Residents are supported to maintain their independence mobilising in the facility and around the secure gardens. Records sampled confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>There is an abuse and neglect policy and staff interviewed understood how to report such incidents if suspected or observed. The facility manager (FM) and nurse consultant (NC) reported that any allegations of neglect if reported would be taken seriously and immediately followed up. There are no documented incidents of abuse or neglect in the records sampled. The nurse practitioner (NP) reiterated that there was no evidence of any abuse or neglect reported. Family/whanau interviewed expressed no concerns regarding abuse, neglect or culturally unsafe practice.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>The required policies on cultural appropriateness are documented. Policies refer to the Treaty of Waitangi and partnership principles. The Maori Health plan includes a commitment to the principles of the Treaty of Waitangi and identifies barriers to access. It also recognises the importance of whanau. Assessments and care plans document any cultural/spiritual needs. Special consideration to cultural needs is provided in the event of death as described by staff. The required activities and blessings are conducted when and as required. All staff receive cultural awareness training. There were residents who identify as Maori at the time of the audit and their cultural needs were met as reported by the interviewed family.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values,</p>	FA	<p>Cultural needs are determined on admission and a care plan is developed to ensure that care and services are delivered in a culturally and/or spiritually sensitive manner in accordance with protocols/guidelines as recognised by the family/whanau. Values and beliefs are discussed and incorporated into the care plan. Family members interviewed confirmed they are encouraged to be involved in the development of the long-term care plans. Residents' personal preferences and special needs were included in care plans sampled.</p>

and beliefs.		
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and this was confirmed by the residents. The induction process for staff includes education related to professional boundaries, expected behaviours and the code of conduct. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation. The facility manager stated that there have been no reported alleged episodes of abuse, neglect or discrimination towards residents.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service encourages and promotes good practice through ongoing professional development of staff. The nurse practitioner (NP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests. Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice.</p> <p>Policies and procedures are linked to evidence-based practice.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Family members stated they were kept well informed about any changes to their relative's health status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records sampled. Staff understood the principles of open disclosure, which is supported by policies and procedures.</p> <p>Staff know how to access interpreter services if required. Staff can provide interpretation as and when needed; the use of family members and communication cards is encouraged.</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>	FA	<p>The organisation is currently governed by a board of directors under Goodwood Park Healthcare Group. The mission and goals are displayed at the front entrance of the facility. The directors meet quarterly, and a current strategic and business plan were sighted.</p> <p>The strategic and business plans, which are reviewed two yearly, outline the purpose, values, scope, direction and goals of the organisation. The documents describe annual and long-term objectives and the associated operational plans. Monthly/quarterly reports to the board of directors showed adequate information to monitor performance including potential risks, contracts, human resource and staffing, occupancy, maintenance, quality management and</p>

		<p>financial performance.</p> <p>Organisational performance is monitored in an ongoing manner. The facility manager meets with the general manager (GM) every week to discuss business performance. The facility manager is a registered nurse and has been in the position for 30 years and maintains training hours in management and nursing scope of practice. The facility manager is supported with day to day operations by the general manager, nurse consultant, administrator, charge nurses and quality/clinical coordinator. Charge nurses from the two respective wings are responsible for the clinical care of the residents and they meet every week with the FM to discuss general clinical care.</p> <p>There is an established governance structure in place. There are four directors. Two of the board members have a clinical background, one is a chartered accountant and the other has a legal background.</p> <p>Seadrome home and hospital currently provides a secure unit of 25 beds for residents with dementia who are able to mobilise independently, and 20 hospital (Geriatric) beds for residents with dementia who are unable to mobilise independently. There were 43 residents at the time of audit, 24 in the dementia unit and 19 in the hospital. Four residents were under the age of 65 years (three in the dementia unit and one in the hospital). Additional contracts are held with the district health board for the provision of respite and day stay services.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>The nurse consultant (NC) acts as the facility manager when the FM is on leave, with support from the office manager and members of the board of trustees who visit on a regular basis and are contactable by phone. Job descriptions and interviews of the manager and staff confirmed their responsibility and authority for this role.</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 planned quality and risk management system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, internal and external audit programme, regular family/resident satisfaction surveys, monitoring of outcomes, clinical incidents and accidents including infection control surveillance.</p> <p>Meeting minutes sampled confirmed that review and analysis of some quality indicators is completed and that the related information is reported and discussed at the management team meeting and staff meetings. Staff reported their involvement in quality and risk management</p>

		<p>activities through audit activities. Relevant corrective actions are developed and implemented to address any shortfalls.</p> <p>Policies cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool process. Policies are based on best practice and are current and appropriate to address the needs of hospital level of care residents under (LTSCH) contract. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The risk register is in place and includes risks associated with clinical, human resources, legislative compliance, contractual and environmental risk. Any identified risks are reported to staff and management. The facility manager described the process for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The facility manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements.</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>There is an open disclosure policy. Adverse, unplanned or untoward events are systematically reported on incident/accident forms. All adverse events are coded and analysis to find patterns and opportunities for improvement are presented and discussed at staff meetings. Adverse event information and outcomes are included in Board reports. Review of incident/accident reported confirmed this. Resident's files evidenced communication with families following adverse events involving the person supported, or any change in the person's support. Family confirmed this.</p> <p>Staff demonstrated awareness of essential notification reporting. There has been an infection outbreak and a reportable incident since the last audit and essential notifications were made to the Ministry of Health.</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>PA Low</p>	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs) where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the providers agreement with the DHB. There are</p>

		<p>enough trained and competent RNs who maintain their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training. Competency assessment questionnaires are completed for medication management and restraint/challenging behaviour. All staff are competent to safely meet the needs of residents requiring hospital (medical) services.</p> <p>An improvement is required to ensure orientation for new staff is completed at commencement of employment and annual performance appraisals are completed in a timely manner.</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 and implemented process for determining staffing levels and skill mixes to provide safe care to residents, 24 hours a day, seven days a week. The service adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster is in place, with staff reporting that good access to advice is available when required. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of a four -week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. Agency registered nurses are used when needed. At least one staff member on duty has a current first aid certificate and there is RN cover on duty every shift.</p> <p>Staff on every shift are skilled and competent to deliver care safely to residents requiring hospital (medical) services.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>Resident information is collected and stored in accordance with the New Zealand Health Records Standard. A resident file is created prior to admission and essential information is entered on the day of admission. For example, medical conditions, medicines, next of kin and emergency contact numbers, initial assessments and the referral information. The front sheet of the record contains the unique personal identifying information, such as the resident's national health index number (NHI), date of birth, legal name, preferred name, past medical history, presenting medical and physical conditions, allergies/sensitivities, current GP, ethnicity, current support needs levels and gender.</p> <p>The current resident records are filed in both dementia and hospital nurses' stations filing cabinets which are locked when not in use or unattended. Archived records of past and deceased residents are stored in a secure place.</p> <p>The residents' records sampled demonstrated that entries were legible, and the writer of each entry signed their name, initials and designation. Records were integrated with information from</p>

		all disciplines and external providers.
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	Admission information packs for Seadrome Home and Hospital are provided for families and residents prior to admission or on entry to the service. The policy has all the required aspects of management of enquiries and entry. Family/whanau interviewed confirmed that they received information regarding the services to be provided. Residents' entry into the service is facilitated in a competent, equitable, timely and respectful manner.
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	A documented process for the management of transfers and discharges is in place. A standard transfer notification form and yellow envelope is utilised when residents are transferred to the public hospital or another service. Residents and their families are involved in all exit or discharges to and from the service, there was evidence in residents' files to confirm this.
<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>	FA	<p>The medication management system is implemented to ensure that residents receive medicines in a secure and timely manner. Medications are stored securely in the trolley and locked cupboards. Medication reconciliation is conducted by registered nurses. Medications are reviewed three monthly and as required by the nurse practitioner. Allergies are clearly indicated, and photos current for easy identification.</p> <p>An annual medication competency is completed for all staff administering medications and medication training records were sighted. A registered nurse was observed administering medicines and complying with required medication protocol guidelines and legislative requirements.</p> <p>There were no residents self-administering medications at the service. Staff were aware of self-administration medication policy requirements. Weekly and six-monthly controlled drug stock takes are conducted, and all medications are stored appropriately. Monitoring of medication fridge temperatures is conducted, and records were sighted.</p> <p>Medicine management policies and procedures are adequate to cater for hospital level residents when required.</p>
<p>Standard 1.3.13: Nutrition, Safe Food,</p>	FA	Meal services are prepared on site and served in dining rooms. The four weekly seasonal rotating menus has been reviewed by the registered dietitian. Diets are modified as required and the

<p>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>cooks confirmed awareness on dietary needs required by the residents. Alternative meal options are offered as required. The residents' weights are monitored monthly and supplements are provided to residents with identified weight loss issues. Snacks and drinks are available for residents who wake up during the night on a 24-hour period. The family/whanau interviewed acknowledged satisfaction with the food service.</p> <p>The kitchen was audited and registered under the food control plan. Kitchen staff completed training in food safety/hygiene. The kitchen and pantry were sighted and observed to be clean, tidy and stocked. Labels and dates are on all containers and records of food temperature monitoring, fridges and freezers temperatures are maintained. Regular cleaning is conducted.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The facility manager reported that all consumers who are declined entry are recorded. When a consumer is declined entry, family/whanau and the consumer are informed of the reason for this and made aware of other options or alternative services available. The consumer is referred to the referral agency to ensure that the consumer will be admitted to the appropriate service provider.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	PA Low	<p>There was evidence in files sampled that the RN completes an initial admission assessment within 24 hours which includes relevant risk assessment tools for all residents. Resident needs and supports are identified through the ongoing assessment process in consultation with the resident/relative and significant others.</p> <p>Of the seven files reviewed three residents (not under the ARC) did not require interRAI assessments. Four long-term residents under the ARC had InterRAI assessments completed within the required time frame. Additional assessments for management of wound care were appropriately completed according to need.</p> <p>The long-term care plans reflected the outcome of the assessments. The previous improvement required in relation to completing interRAI assessments in a timely manner had been addressed and maintained.</p> <p>An improvement is required to ensure that wound dimensions and progress for wound healing are entered in wound management care plans for residents in hospital level care.</p>

<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>The registered nurse develops the long-term support plan from information gathered over the first three weeks of admission. The support plans sampled reflected the outcomes of risk assessments and were resident focused. Interventions clearly described support required. Each resident file sampled had a risk management plan and these detailed risks relating to the resident's medical and behavioural problems and alerts such as high falls risk.</p> <p>There was documented evidence of resident/relative/whanau involvement in the support planning process as was appropriate. The family/whanau interviewed confirmed care delivery and support is consistent with their expectations and plan of care. Behaviour management plans include triggers, strategies for de-escalation and interventions.</p> <p>Short term care plans are used to document any changes in health needs with interventions, management and evaluations. Short term care plans sighted included management of wounds and infections.</p> <p>Nurse practitioner notes and allied health professional progress notes are evident in the resident's files sampled.</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>The nursing staff initiates a review when there is a change in the resident's condition and arranges a nurse practitioner or nurse specialist visit if required. There is evidence of three-monthly medical reviews, or the nurse practitioner will visit earlier if there is a change in health status. Residents and relatives interviewed confirm care delivery and support by staff is consistent with their expectations. Families confirmed they were kept informed of any changes to resident's health status. Resident files sampled recorded communication with family. Progress notes are completed on every shift. Staff report there are adequate clinical supplies.</p> <p>There were two wounds and two pressure injuries being treated on the day of the audit. One hospital resident had one wound and two pressure injuries; one pressure injury was a stage two and one wound was a non-facility acquired stage three pressure injury. (A section 31 was completed for this wound). There was nurse practitioner input for care requirements for these wounds. One dementia resident had a lesion (the nurse practitioner had provided input on care requirements).</p> <p>Pressure injury prevention interventions were documented in the care plans for residents identified at risk of pressure injury.</p> <p>Behaviour management plans are developed with multi-disciplinary input and describe types of behaviour, possible triggers and interventions. The NP initiates any specialist referrals to the mental health services. The files sampled specified prevention-based strategies for minimising</p>

		<p>episodes of challenging behaviours and described how the residents' behaviours were managed over a 24- hour period.</p> <p>Resident care plans (short-term and long-term) document appropriate interventions to manage clinical risk such as poor mobility, falls, skin integrity and nutrition. Care staff interviewed confirmed they are updated of any changes in resident's care or treatment during handover sessions.</p> <p>There are adequate appropriate links with other services and organisations to support hospital level of care residents and their families for example: Church groups, local Marae, Returned Services Association (RSA), local district health boards and schools.</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>	FA	<p>The service employs a diversional therapist (DT) four days per week, and an occupational therapist three hours per week. The team provide activities across the dementia section and hospital. Care assistants were also observed during the days of the audit providing musical sessions for residents.</p> <p>The activities programme is displayed on a calendar. Activities include music, movies, word, tai chi, dancing and walk and talk sessions. Maori Te Wa hui are held weekly with a boil-up and hangi following this. One to one session is also scheduled for residents.</p> <p>The occupational therapist interviewed utilises a sensory assessment and uses the Pool Activity (PAL) Checklist; and works with the sensory assessment team comprised of the Facility Manager, an RN and a care assistant. A sensory cues summary is compiled and an assessment summary and plan which informs the residents activity programme. Residents' files sampled reflect their preferred activities. These are evaluated every six months or as when necessary. 24-hour activities are addressed in person-centred long-term care plans to manage residents with behaviours of concern. The DT and OT develop an activity planner for hospital, dementia and under 65 years. The DT has oversight on activities on the hospital wing conducted by care staff. Residents' activities information form is completed in consultation with the family during the admission process.</p> <p>The residents were observed participating in a variety of activities on the audit days. There are regular outings for all residents (as appropriate). Family/whanau interviewed reported satisfaction with the activities provided.</p>
Standard 1.3.8: Evaluation	FA	<p>There was evidence that residents' care plans are personalised and reflect interRAI assessments and assessments. Activity plans are evaluated at least every six months and updated when</p>

<p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>		<p>there are any changes. The evaluations record how the resident is progressing towards meeting their goals and responses to interventions. Short term care plans are developed when needed and signed and closed out when the short-term problem has resolved.</p> <p>Initial care plans for long-term residents were evaluated by the registered nurses within three weeks of admission.</p> <p>Long-term care plans have been evaluated by the registered nurses six monthly or earlier for any health changes in the resident files reviewed. Family are invited to attend the multidisciplinary review meeting and are consulted in the review process. Written evaluations reviewed, identified if the resident goals had been met or unmet. The NP reviews the residents at least three monthly or earlier if required. Ongoing nursing evaluations occur as indicated and are documented within the electronic progress notes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>There is a documented process for the management of all referrals. The service utilises a standard referral form when referring residents to other service providers. The NP confirmed that processes are in place to ensure that all referrals are followed up accordingly. Family/whanau are kept informed of the referrals made by the service. All referrals are facilitated by the nurse practitioner and nursing team.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>Policies and procedures are in place for handling waste and hazardous substances. Processes for the collection, storage and disposal of biomedical waste, household rubbish and recyclables are in accord with infection control principles and comply with local body requirements.</p> <p>Cleaning staff have received training in the handling of chemicals and hazardous waste. Chemicals are delivered by an external provider. Chemicals are accessed through a closed chemical dispensing system. Secure storage is provided. Safety data sheets are available in the laundry and cleaner's room. Personal protective equipment is provided and observed to be used by staff.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical</p>	<p>PA Low</p>	<p>Enclosed gardens and safe, sheltered external areas with suitable seating is available. Mobile residents are protected from traffic on the driveway by a key coded gate with a further key coded gate at the exit on to the road. Pathways, verandas and walkways enable residents to walk in the</p>

environment and facilities that are fit for their purpose.		<p>grounds and there are ample safe areas outside for residents to wander.</p> <p>A refurbishment programme to upgrade the facility is underway, with painting and refurbishments evident. An improvement is required to ensure fire extinguishers are regularly checked.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are enough individual toilets and bathrooms provided. Some bedrooms have an ensuite. Bathrooms are fitted with handrails, non-slip flooring and call bells. Finishing materials are waterproof. Reversible door catches and privacy curtains are installed in each bathroom. Hot water is monitored routinely, where a variation occurs this is followed up. All staff carry hand gel and there is a hand basin in each room.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>There are sufficient bedrooms to accommodate 25 residents in the rest dementia area and 20 residents in the hospital. There are three shared rooms in the dementia area. This has been approved by family members. Rooms used for hospital residents are of sufficient size to accommodate residents requiring hospital level care, allowing for mobility aids, equipment and staff caring for the resident. Electric beds are provided for hospital residents. There is adequate room in all bedrooms for personal possessions. Each bed space is provided with a wall light and a nurse call bell. Family/whanau interviewed confirmed that bedrooms were adequate for their family members needs and that personal space is respected.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>There are separate well-furnished lounges and dining areas for the hospital and the dementia area. Activities are provided in the lounge areas and in a separate recreation room. Alternative additional small sitting areas are available in each area. The communal areas are sufficient to accommodate all the residents. There is a variety of seating to suit all needs. There is room to accommodate wheelchairs and walkers. Family/whanau confirmed that the lounges and dining areas meet their needs. Surveys provide residents/family with the opportunity to provide feedback regarding the facility.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p>	FA	<p>All personal clothing and laundry are laundered on site. There is a laundry person employed seven days a week. There is a defined clean and dirty area of the laundry and an entry and exit door. The laundry is well equipped, and the machinery is regularly serviced. Personal protective</p>

<p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>		<p>clothing is available including gloves, aprons and face masks. Adequate linen supplies were sighted. There are policies and procedures which provide guidelines regarding the safe and efficient use of laundry services.</p> <p>Cleaners are available daily to clean the many communal living areas, toilets and room cleans. The cleaner's cupboard containing chemicals is locked. Cleaner's trolleys are well equipped and kept in locked areas when not in use. All chemicals have manufacturer labels. Cleaning staff were observed to be wearing appropriate personal protective equipment. The environment on the day of audit was clean and tidy. There is a daily and monthly room clean schedule. The cleaning staff have completed chemical safety training. Documented material safety data sheets are available in work areas.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>All staff receive training on emergency management and evacuation procedures. There is an approved fire evacuation plan and have been no changes to the building or services since the approval date. Fire systems and equipment are checked annually during the building warrant of fitness inspection (Refer 1.4.2.1). Evacuation drills are completed every six months.</p> <p>The building has emergency lighting in the event of a power failure. Alternative sources for cooking and heating are accessible. There is a well-stocked civil defence kit and a sufficient amount of emergency water. There are first aid supplies and staff have completed first aid training. There are additional supplies for a pandemic. All resident areas have call bells, including toilets and showers. Monthly call bell audits are conducted by the quality coordinator and records were sighted. The level of support each resident would need in the event of an emergency is documented in their care plan.</p> <p>There are several clearly marked exits from the building. All exits in the dementia wing require keys or codes to enter from the outside. All doors release automatically when the fire alarm activates. External doors and windows are checked each evening and monthly security checklist are completed to ensure the facility always remains safe and secure. Families interviewed confirmed that they felt the residents were safe and secure.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe</p>	<p>FA</p>	<p>The facility has plenty of natural light. All bedrooms have external opening windows, and some have doors to the garden. There is plenty of natural ventilation. The hospital wing has under floor heating with thermostat controls. There is wall mounted electric panel heaters in communal rooms, corridors and bedrooms in the dementia area. Observations during the audit indicated that the internal environment is maintained at a comfortable temperature. A small sheltered area away</p>

and comfortable temperature.		from the main building is available for residents who smoke.
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>Seadrome Home and Hospital provides an environment that minimises the risk of infection to residents, staff and visitors by implementing an appropriate infection prevention and control programme. The charge nurse (CN) is the infection control coordinator (ICC) and is assisted by the quality coordinator (QC). They have access to external specialist advice from an NP and DHB infection control specialists when required. A documented role description for the ICC including role and responsibilities is in place.</p> <p>The infection control and prevention programme are reviewed annually and is incorporated in the monthly meetings and a review of the education programme is conducted. Staff are made aware of new infections through daily handovers on each shift and progress notes. The infection control and prevention programme are appropriate for the size and complexity of the service.</p> <p>There are processes in place to isolate infectious residents when required. Hand sanitisers and gels are available for staff and visitors to use. There has been an infection outbreak since the last audit, and this was managed according to documented infection control and prevention guidelines and evidence was sighted. Staff interviewed demonstrated an understanding of the infection prevention and control programme.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The ICC and QC are responsible for implementing the infection control programme and indicated there are adequate human, physical, and information resources to implement the programme. Infection control reports are discussed at the management quality meetings and monthly staff meetings. Both have access to all relevant resident data to undertake surveillance, internal audits and investigations respectively.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and</p>	FA	<p>The organisation has documented policies and procedures in place that reflect current best practice. Staff were observed to be following the infection control policies and procedures. Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand washing technique and use of disposable aprons and gloves. Staff demonstrated knowledge on the requirements of standard precautions and able to locate policies and procedures.</p>

procedures are practical, safe, and appropriate/suitable for the type of service provided.		
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>Staff education on infection prevention and control is conducted by the ICC, quality coordinator and other specialist consultants. The infection control coordinator and quality coordinator attended infection prevention and control training conducted by an external consultant to keep their knowledge current. A record of attendance is maintained and was sighted. The training education information pack is detailed and meets best practice and guidelines. Training is conducted to family/whanau and residents who can still comprehend and follow basic instructions. This is documented in their respective progress notes. External contact resources included the NP, laboratories and local district health boards. Staff interviewed confirmed an understanding of how to implement infection prevention and control activities into their everyday practice.</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 control programme.</p>	FA	<p>The infection surveillance programme is appropriate for the size and complexity of the organisation. Infection data is collected, monitored and reviewed monthly. The data is collated and analysed to identify any significant trends or common possible causative factors and action plans are implemented. Staff interviewed reported that they are informed of infection rates at monthly staff meetings and through compiled reports. The NP is informed within the required time frame when a resident has an infection and appropriate antibiotics are prescribed to combat the infection respectively.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Seadrome Home and Hospital has a commitment to provide quality services for residents in a safe environment and work to minimise the use of restraint. The restraint coordinator provides support and oversight for enabler and restraint management in the facility. Restraint is part of orientation and training is provided annually or as necessary. Approved restraint includes bed rails, environmental restraint in the form of locked gates and perimeter fencing. Codes are displayed and family/whanau come and go as they please. Staff interviewed were clear regarding the difference between a restraint and enabler use. There were no residents using restraint, but one resident was using bedrails as an enabler for them to feel safe and aid mobility while in bed.</p>

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)
Criterion 1.2.7.4 New service providers receive an orientation/induction programme that covers the essential components of the service provided.	PA Low	Staff orientation records for old staff were sighted however there was no evidence of orientation for new staff. Staff reported that the orientation process prepared them adequately for their role.	No evidence of orientation for new staff was sighted in staff files sampled.	Provide evidence that orientation for all staff is completed. 180 days
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service	PA Low	Staff performance is monitored, and annual performance appraisals were sighted in some files sampled. All staff have who work in the dementia unit have completed dementia level training. An improvement is required to ensure annual performance appraisals are consistently completed for all staff.	Annual performance appraisals were not completed	Provide evidence that staff annual performance appraisals

providers to provide safe and effective services to consumers.			within the required timeframes.	are completed in a timely manner. 180 days
Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.	PA Moderate	<p>Long-term resident files were reviewed, and these include, residents based in the hospital and dementia section. All resident files identified that the nursing staff had undertaken an initial assessment, appropriate risk assessments and developed an interim care plan for residents on admission.</p> <p>The first interRAI assessment and long-term care plans were completed for residents under the ARCC contract whose files were reviewed. Care plans had been evaluated at least six monthly or more often as needed. The outcomes of interRAI assessments link to the long-term care plan with appropriate interventions to meet the resident goals. Care plans for all residents' files reviewed had not been completed within the 21 days required period.</p>	Completion of the long-term care plan for all seven resident files reviewed had not been completed within 21 days.	Provide evidence that long-term care plans for all resident files are completed within 21 days. 90 days
Criterion 1.3.3.4 The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.	PA Moderate	Residents in the hospital section of the facility had regular RN entries in their progress notes. There was no evidence of regular documentation in progress notes in the dementia section by RNs.	There was no evidence that RNs are regularly reviewing progress notes for residents' files sampled in the dementia section.	Provide evidence that RNs regularly document and review progress notes for residents within the dementia section. 90 days

<p>Criterion 1.3.4.2</p> <p>The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.</p>	<p>PA Low</p>	<p>Wound management care plans are developed for residents with wounds. Wound dimensions and progress for wound healing was documented for residents in the dementia section. Wound dimensions and progress for wound healing were not entered in wound management care plans in hospital level care.</p>	<p>Wound dimensions and progress for wound healing were not entered for three wounds in hospital level care.</p>	<p>Ensure wound dimensions and progress for wound healing are documented in wound management plans.</p> <p>90 days</p>
<p>Criterion 1.4.2.1</p> <p>All buildings, plant, and equipment comply with legislation.</p>	<p>PA Low</p>	<p>There is a planned maintenance programme. A maintenance contractor is currently providing services 36 hours per week and provides after hours services as required. Access is available to afterhours contractors as required. There is a maintenance inspection checklist with evidence that maintenance concerns are identified and followed up in a timely manner. A maintenance worksheet identifies maintenance requirements. Furnishings, fittings and floorings are maintained and suitable for the care and support of residents. Applicable building regulations and requirements are met. There is a current building warrant of fitness which expires in 3 September 2020.</p> <p>Spacious lounge and dining areas are provided. There is enough space for the use and storage of mobility aids. Staff report there is sufficient equipment and supplies available. The hoists and weighing scales are functionally maintained. Medical equipment is calibrated annually. Electrical equipment is tested. Fire extinguishers were tagged as showing they had been checked on July 2018. There was no evidence to demonstrate that fire extinguishers had been checked in the last 12 months.</p>	<p>There was no evidence that fire extinguishers had been checked in the last 12 months.</p>	<p>Provide evidence that fire extinguishers are checked as required by legislation.</p> <p>90 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.