

Goodwood Park Health Limited - Goodwood Seadrome Ltd

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 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 - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Dementia care
Dates of audit:	Start date: 14 April 2021 End date: 14 April 2021
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	41

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 hospital 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), quality coordinator (QC), charge nurses (CNs) and the quality manager (QM) from another sister facility. 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 surveillance audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board (DHB). The audit process included a review of areas of improvement identified during the last certification audit, review of relevant policies and procedures, samples of residents' and staff files, observations and interviews with residents, staff, and the nurse practitioner (NP). The NP and residents spoke positively about the care provided.

There are two areas requiring improvement relating to water temperature checking and expired pro re nata (PRN) medicines held in stock.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to interpreting services if required. Four family members interviewed stated they were confident that they were kept informed of happenings including unplanned or adverse happenings, any concerns or follow-up and the outcome.

A complaints register is maintained with complaints resolved promptly and effectively in line with the Code of Health and Disability Services Consumers' Rights (the Code).

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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The Board of Directors, that meets monthly and the management team of Goodwood Seadrome Ltd (Seadrome) ensure that services are planned, co-ordinated and appropriate to the needs of the residents of the hospital and dementia unit. The purpose, vision, values, and goals of Seadrome are included in the five-year strategic plan that is reviewed annually to determine review direction and progress to reach agreed goals.

The incident management system captures all incidents, accidents, and adverse events on the database. The system enables follow-through, how these are managed, and the measures put in place, and how to prevent them in the future as evidenced with the adverse event that had occurred in the past 18 months. Policies and procedures are reviewed as per the schedule.

The general manager mental health and aged care (GM MH/AC), quality assurance manager (QAMgr), clinical lead (CL) and facility and service manager (FSMgr), continue to monitor organisational performance with the support of the staff (charge nurse (CN), registered nurse (RN), healthcare assistants (HCA), diversional therapist (DT), cook, kitchen hand (KH), gardener, maintenance man and laundry). The required policies and procedures are documented and available and reviewed every three years as per policy. There is a quality plan with key quality objectives. A range of quality data is collected. Actual and potential risks are identified and mitigated. An internal audit schedule is implemented.

Seadrome has a proactive recruitment, retention, and workforce development plan, including a documented core training calendar and staff have opportunity to engage in opportunities to develop skills to enhance service delivery or contribute to career advances. Training happens regularly to keep quality standards consistent across the organisation. All staff have current first aid, practicing certificates or registration as required, and at least one qualification. Staffing is rostered to meet the needs of the residents which are reviewed each handover.

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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Policies and procedures provide documented guidelines for access to service. Residents are assessed prior to entry to the service to confirm their level of care. The registered nurses (RNs) are responsible for assessment, development, and evaluation of care plans. Care plans are individualised and based on the residents' assessed needs and routines. Interventions are appropriate and evaluated in a timely manner.

The service provides planned activities that meet the needs and interests of the residents as individuals and in group settings. There is a medicine management system in place. Three monthly medication reviews are conducted by the nurse practitioners (NPs) and these were current. Staff involved in medication administration are assessed as competent.

The food service provides and caters for residents. Specific dietary likes and dislikes are accommodated. Residents' nutritional requirements are met. Nutritional snacks are available for residents 24 hours.

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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Seadrome has a current building warrant of fitness expiring 3 September 2021. Fire drills are conducted each six months, fire extinguishers, sprinkler system and hoses are checked by a specialist agency. Essential emergency supplies (BBQ, food, water, PPE, residents' medical requirements and equipment) and an emergency plan are in place.

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 organisation has policies and procedures that support the minimisation of restraint. There was one resident using an enabler and no residents using restraints on the day of the audit. The use of enablers is voluntary for the safety of residents in response to individual requests. Staff education on restraints, enablers and the management of challenging behaviour is provided.

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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There is a documented surveillance programme that is appropriate to the size and scope of the service. All infections are recorded, with data collated each month, and then annually. Analysis and comparisons are made.

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	16	0	2	0	0	0
Criteria	0	43	0	2	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	There have been two complaints since the certification audit in September 2019 which are recorded, investigated, responded to and corrective actions taken all in a timely fashion. One complainant gave few details to investigate, however, management took extra steps to determine that the complaint was dealt with as a learning opportunity to establish that residents were not negatively affected.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment	FA	Residents and family interviewed confirmed communication with staff was open and that they were well informed. The review of residents' files showed residents were informed of any significant events or changes in care provision. Staff interviewed (GM MH/AC, QAMgr, CL, FSMgr, CN, RN, HCA, DT), were able to describe open disclosure, how this is implemented and how to access interpreter services if required.

conducive to effective communication.		
<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>There is an established governance structure in place. Seadrome’s board of directors, two have a clinical background, one is a chartered accountant and the other has a legal background, along with senior management staff, have reviewed and confirmed the mission, values, and goals. These are displayed at the front entrance of the facility and in other areas. The directors meet monthly, and the current strategic and business plan has been reviewed and the updated 2021 to 2026 Strategic and business plan is to be tabled at the May 2021 board meeting. The strategic and business plan outlines the purpose, values, scope, direction, and goals of the organisation. The documents describe annual and long-term objectives and the associated operational plans. Monthly reports to the board of directors show that adequate information to monitor performance is reported which includes potential risks, contracts, human resource and staffing, occupancy, maintenance, quality management and financial performance.</p> <p>The FSMgr and GM MH/AC weekly to discuss business performance. The FSMgr is an RN (30yrs in position) that maintains training hours in management and nursing scope of practice. The FSMgr is supported with day-to-day operations by the GMgr MH/AC, CL, QAMgr, CN, administrator, RNs, and DT to maintain standards. CNs from the two respective wings (Dementia and Hospital) are responsible for the clinical care of the residents and they meet every week with the FSMgr to discuss levels of clinical need and determine appropriate staffing levels.</p> <p>Seadrome is a secure facility currently 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 41 residents at the time of audit, 24 in the dementia unit and 17 in the hospital. Three 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 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management</p>	FA	<p>There is a documented quality and risk management system. Policies and procedures identify quality outcomes for key components of service delivery, there is reference to the interRAI Long Term Care Facility (LTCF) assessment tool process. These comply with legislation, standards, and are appropriate to address the needs of hospital level of care residents under (LTSCH) contractual requirements. The current version of all policies, procedures and work instructions are available to staff. All obsolete documents are identified and removed from circulation.</p> <p>Quality plans and processes are based on a continuous quality improvement model and the organisation continues to implement a number of service improvements. The quality development and risk management plan is reviewed annually and takes into account feedback from residents, family, and staff. Quality goals and objectives are</p>

<p>system that reflects continuous quality improvement principles.</p>		<p>documented in measurable terms. The QAM provides the board with monthly reports against the quality objectives. Quality team meetings occur monthly with representatives from throughout Goodwood group. Meeting minutes sampled confirmed that matters were discussed at all levels.</p> <p>The clinical quality and risk management plan includes risk management strategies relating to business, finance, operational activities, service delivery and emergency management. Health and safety procedures comply with legislation and guidelines.</p> <p>Internal audits are carried out and recorded as planned and include corrective actions when required</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>Adverse event reporting is planned, conducted, and reported as part of the quality and risk management system. Event report forms are documented for incidents, accidents, repairs, infections, and hazards. All event report forms are collated and discussed at the quality meetings. All incident records sampled had been appropriately managed and closed as required. There is evidence that deficits are remedied, and improvements are made as required. Recent quality and staff meeting minutes sampled confirmed correct reporting of all adverse events. An analysis is included, and no trends were identified.</p> <p>Since the last audit there has been one resident with an infection which is currently being treated and monitored, for which an essential notification was made to the Ministry of Health under section 31.</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</p>	<p>FA</p>	<p>Staff that require professional qualifications have them validated as part of the employment process and annually. A copy of the current APC was sighted for the staff that require them.</p> <p>Policies and procedures identify human resources management that reflects good employment practice and meets the requirements of legislation. Staff files evidence reference checking, police vetting for all starting employment since 2019 and those employed previously are scheduled to be vetted on the anniversary of their start date this year. Recruitment processes that actively seek people with the language skills in addition to the qualifications needed to meet the residents' needs are implemented. Job descriptions clearly describe staff responsibilities and best practice standards. Staff have all completed an orientation programme with specific competencies for their roles. The staff files confirmed orientation, performance reviews and ongoing education is implemented.</p> <p>Mandatory and continuing staff education comprise in-service trainings onsite, off site seminars and training days to ensure all aspects of service delivery are met. HCA staff have either completed or commenced a New Zealand</p>

legislation.		Qualification Authority education programme to meet the requirements of the providers agreement with the DHB. Staff working in the dementia unit have completed a dementia level four qualification. There are at least two staff members on each shift in the dementia unit with help from the RN covering the hospital wing. All staff are competent to safely meet the needs of residents requiring hospital (medical) services. CNs and RNs are competent to undertake interRAI assessments. Competency assessment questionnaires are completed for medication management and restraint/challenging behaviour.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	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. HCA 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 and on-call when required. Staff on every shift are skilled and competent to deliver care safely to residents requiring hospital (medical) services.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Low	The medicine management policies and procedures clearly outline the service provider's responsibilities in relation to all stages of medicine management. Medications were stored in a safe and secure way in the trolley and locked cupboards. Medication reconciliation is conducted by the registered nurses (RNs) when the resident is transferred back to service from hospital or any external appointments. Medication competencies were completed annually for all staff administering medication. There were no residents self-administering medicines at the time of the audit. Self-administration medication policy and procedure is in place when required. An improvement is required to ensure all expired PRN medication held in stock are returned to the pharmacy in a timely manner.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's	FA	Meal services are prepared on site and served in respective dining rooms. The four weekly seasonal rotating menu has been reviewed by the registered dietitian. Diets are modified as required and the 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

<p>individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>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 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>Residents have their level of care identified through the needs assessment by the needs assessment agency (NASC). The initial assessments were completed within the required time frame on admission while care plans and interRAI were completed within three weeks according to policy. Assessments and care plans are detailed and include input from the residents, family/whanau, and other health team members as appropriate. The nursing staff utilise standardised risk assessment tools on admission. In interviews residents and relatives expressed satisfaction with the assessment process.</p> <p>The previous area requiring improvement relating to wound dimensions and progress for wound healing being entered in wound management care plans for residents in hospital level care was completed.</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>All care plans reviewed evidenced that interventions were adequate to address the identified needs of residents. Significant changes were reported in a timely manner and prescribed orders carried out. The QC reported that the NP's medical input was sought within an appropriate timeframe, that medical orders were followed, and care was person centred. Care staff confirmed that care was provided as outlined in the care plan. A range of equipment and resources are available, suited to the level of care provided and in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their</p>	<p>FA</p>	<p>Planned activities are appropriate to the residents' needs and abilities. Activities are conducted by the DT four days per week, and an OT five hours per week. The activities are based on assessment and reflected the residents' social, cultural, spiritual, physical, cognitive needs/abilities, past hobbies, interests, and enjoyments. Residents' birthdays are celebrated. The activity programme is formulated by the activities staff. The activities are varied and appropriate for people living with dementia, hospital level of care and under 65 years. 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 on notice boards. These include word games, skittles, walking, bible reading, tai chi, music therapy, manicure, and massage. Maori Te Wa hui are held weekly with a boil-</p>

<p>needs, age, culture, and the setting of the service.</p>		<p>up and hangi following this. Group and one to one sessions are conducted.</p> <p>The DT 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.</p> <p>Twenty-four-hour activity plans reflect residents' preferred activities of choice and are evaluated every six months or as necessary. Activity progress notes and activity attendance checklists were completed in a timely manner. The planned activities and community connections are suitable for the residents. There are regular outings/drives, for all residents (as appropriate). Family members reported overall satisfaction with the level and variety of activities provided. The DT has oversight of 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>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Resident care is documented on each shift by the RNs and care staff in the progress notes. All noted changes by the health care assistants (HCAs') were reported to the nursing team in a timely manner.</p> <p>Formal care plan evaluations, following reassessment to measure the degree of a resident's response in relation to desired outcomes and goals occurred every six months or as residents' needs change. These were carried out by the RNs in conjunction with family, the NPs', and specialist service providers. Where progress was different from expected, the service responded by initiating changes to the service delivery plan.</p> <p>Short term care plans were reviewed weekly or as indicated by the degree of risk noted during the assessment process. Interviews verified residents and family/whānau were included and informed of all changes.</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>	<p>PA Low</p>	<p>Enclosed gardens and safe, sheltered external areas with suitable seating are available for residents' use. 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 grounds and there are ample safe areas outside for residents to wander.</p> <p>There is a planned maintenance programme and a system to capture and correct any incidental maintenance concerns, with a handyman and gardener employed. 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 2021.</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 and fire equipment is tested.</p>

		Water temperatures are checked and recorded at every point where residents use the hot water, shower, and basins, and recorded. The temperature is consistently 35 to 38 degrees Celsius which is not acceptable from an infection control perspective. Ministry of Health Guidelines require a facility such as this to be at 45 degrees Celsius. The service must continue to monitor and record temperatures after correcting to the required level.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	<p>The fire department has approved the fire evacuation procedures; prudently this is currently under review. Trial evacuation drills are conducted six monthly, as scheduled. Records of fire drills were sighted and correct. Fire equipment is tested and readily available.</p> <p>There are documented policies and procedures for all emergencies. A hazard plan is maintained. Staff receive training on emergency management including medical/psychiatric emergencies and natural disasters. There are emergency bells in rooms throughout the facility. All bedrooms have call buttons.</p> <p>The required emergency equipment was sighted at both sites. This includes backup equipment and supplies, including civil defence equipment in the event of an emergency. There are sufficient amounts of water and food supplied.</p> <p>Onsite safety and security processes are documented. Secure entry to the grounds and building operates 24 hours. There is exterior lighting. The administration wing is locked after 7pm or dark. There is awake supervision 24 hours a day. Overnight staff check facility security and conduct random room checks.</p>
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	The 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 weekly charge nurse management, 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.
Standard 2.1.1: Restraint minimisation Services demonstrate	FA	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

<p>that the use of restraint is actively minimised.</p>		<p>necessary. Approved restraint includes bed rails and environmental restraint in forms 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>
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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	<p>Allergies were clearly indicated, and all residents’ photos were current for easy identification. The HCA and RN were observed administering medicines following the required medication protocol guidelines and legislative requirements in their respective wings. The controlled drug register was current and correct. Weekly and six-monthly stock takes were conducted. Monitoring of medicine fridge temperatures is conducted regularly and deviations from normal were reported and attended to promptly. The NP reviews medications every three months and as required. The outcomes of PRN medicines administered were documented.</p> <p>Some PRN medications held in stock had expired.</p>	There were expired PRN medications held in stock.	Ensure PRN medicines held in stock are current and returned to the pharmacy in a timely manner when expired.

				90 days
<p>Criterion 1.4.2.1</p> <p>All buildings, plant, and equipment comply with legislation.</p>	PA Low	Water temperatures are checked and recorded at every point where residents use the hot water, shower, and basins, and recorded. The temperature is consistently 35 to 38 degrees Celsius which is not acceptable from an infection control perspective.	Water temperatures are below an acceptable temperature to meet legislative guidelines of 45 degrees.	<p>Continue to monitor and record hot water temperature at point of resident contact and correct to required temperature of 45°C.</p> <p>60 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.