

Kingswood Healthcare Morrinsville Limited

Introduction

This report records the results of a Surveillance Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

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

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

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

The specifics of this audit included:

Legal entity: Kingswood Healthcare Morrinsville Limited

Premises audited: Kingswood Rest Home

Services audited: Rest home care (excluding dementia care); Dementia care

Dates of audit: Start date: 25 August 2015 End date: 25 August 2015

Proposed changes to current services (if any): The service is in the process of building a new 16 bed dual purpose facility on the grounds.

Total beds occupied across all premises included in the audit on the first day of the audit: 26

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
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Kingswood Healthcare Morrinsville is an aged care facility that provides rest home and specialist secure dementia care for up to 29 residents. One of the strengths of the service is the implementation of the Spark of Life philosophy in the dementia care unit.

This unannounced surveillance audit was conducted against the Health and Disability Services Standards and the service's funding contract with the Waikato District Health Board. This audit also included verification that the renovation of an office space to make a resident's room provides a suitable environment for the resident. The onsite audit included the review of documentation and residents' files, observations and interviews. Interviews were conducted with management, staff, residents, family members and a general practitioner to verify the documented evidence.

The one area requiring improvement from the previous audit related to advance directives has been addressed and embedded into practice. There is one new area for improvement related to recording of refrigeration temperatures.

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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Information is provided to residents and family members in a full and frank manner that reflects the services open disclosure policy. Incidents and accidents or other adverse events are communicated to family as required. There is access to interpreting services when this is required.

The service has processes in place to ensure advance directives comply with legislative requirements, which is an improvement since the last audit. Advance directives are acted on where valid. The service has a documented complaints management system implemented that complies with the Code of Health and Disability Services Consumers' Rights (the Code) and timeframes.

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 organisation's mission statement and vision have been identified in the business plan. Planning covers business strategies for all aspects of service delivery in a coordinated manner to meet residents' needs. The organisation's implementation of the Spark of Life approach to person centred care is identified in strategic and business planning documentation.

The day to day operation of the facility is undertaken by staff that are appropriately experienced, educated and qualified. The management team includes a general manager and clinical manager. The service is managed to ensure the residents' needs are met in an effective, efficient and timely way.

The quality and risk system and processes support safe service delivery. The quality management system includes an internal audit process, complaints management, resident and relative satisfaction surveys and incident/accident and infection control data collection. Corrective action planning is implemented to manage any areas of concern or deficits identified, with documentation showing the evaluation and follow up of the corrective actions. Quality and risk management activities, results and preventative action planning are shared among staff.

The service implements documented staffing levels and skill mix to ensure contractual requirements are met. Human resources management processes and the education programme identify good practice and meet legislative requirements. Specific education is provided on the management of residents living with dementia.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach to care delivery. Services are provided by suitably qualified and trained staff to meet the needs of residents. All internal assessments of resident's needs are undertaken using the electronic interRAI assessment programme. The processes for assessment, planning, provision, evaluation, review, and exit are provided within time frames that safely meet the needs of the resident and meet contractual requirements. The care plans in the rest home and dementia unit reviewed described the needs and interventions required.

Care is evaluated at least six monthly, or sooner if there is a change in the resident's needs, in which case, a short term care plan is implemented. The service provides planned activities in the rest home and dementia unit. Residents are encouraged to maintain links with family and the community. A safe medicine administration system was observed at the time of audit. Staff responsible for medicine management have been assessed as competent to do so.

The residents were highly satisfied with the meal services. The menu has been reviewed by a dietitian and residents' nutritional requirements, preferences and needs are met. Improvement in the recording of temperatures of the fridges (including medication fridge in the rest home) and bain-marie in the kitchen is required.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The rest home and dementia unit have current building warrants of fitness. There have not been any changes to the buildings that have required changes to the approved evacuation scheme.

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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There is no use of restraints or enablers at the service.

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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Surveillance for infections is undertaken monthly. Results of surveillance are analysed to assist in achieving infection reduction. The infection surveillance results are reported to staff and management in a timely manner.

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	1	0	0	0
Criteria	0	39	0	1	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
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 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	The previous audit identified an area for improvement to ensure that advance directive forms comply with legislation. This is now addressed. All advance directives sighted are signed by the resident when they were competent to do so. Any advance directives that the residents have are available to staff. The management and staff demonstrated knowledge on the legal requirements for a valid advance directive and act on the decisions that are made by the resident.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	Complaints forms are available throughout the service. The complaints register and quarterly internal audit on complaints management record that any complaints comply with time frames in Right 10 of the Code. There is one complaint recorded to date in 2015. The complaints register format has sections for any complaints, dates, actions taken and resolution signoff. The management and staff demonstrated knowledge on complaints management. The residents and family members reported that if they need to make a complaint that this is an easy and accessible process.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to	FA	Open and frank information is provided to residents and where appropriate, next of kin and enduring power of attorney. Communication with families is recorded in the residents' files and evidenced on the incident and accident forms. Open disclosure

effective communication.		<p>topics are part of the in-service education programme.</p> <p>Staff are able to effectively communicate with the residents. The staff in the dementia unit have specific training on communication with residents who have cognitive impairment. The service has a policy on accessing interpreting services. All residents are able to communicate in English.</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 service has two buildings onsite, one a secure dementia unit and the other a rest home level of care facility and is in the process of building a new 16 bed rest home/hospital facility. Services are planned to meet the needs of residents at rest home level of care and those living with a diagnosis of dementia and requiring a specialised secure environment. Since the last audit the service converted an office space to add one bedroom to the rest home facility. The service provides care for up to 17 residents in the rest home and 12 in the dementia unit. There were 14 rest home level of care residents, including two residents under the age of 65 and 12 residents in the dementia unit at the time of audit. The service provides long term care and short term respite care.</p> <p>The purpose, values, scope, direction, and goals of the organisation are clearly identified and reviewed on a two yearly cycle. The business and strategic plan for 2013-2015 includes the 'Spark of Life' resident centred approach to dementia care, which is incorporated into the organisation's goals, vision and philosophy. Aspects of the Spark of Life philosophy are also implemented in the rest home.</p> <p>The directors and general manager are responsible for ensuring the overall financial welfare of the service delivery. The general manager reports to the directors formally on a monthly basis, and more often informally. There is a weekly report at management meetings, with a full report on all residents, staff, health and safety, infection control, occupancy and any other matters requiring attention. The general manager also manages the other facilities in Matamata, and works part time at both facilities. The general manager is supported by a clinical manager who works full time at Morrinsville.</p> <p>The clinical manager is a registered nurse (RN) with a job description outlining their role and responsibilities for the clinical management of the service. The general manager reports confidence in the clinical manager's abilities for the management of the clinical aspects of service delivery. The clinical manager and general manager have both attended over eight hours education related to the management of aged care services and other clinical education related to dementia and aged care. The clinical manager has completed the interRAI assessment training.</p>

		The families interviewed and satisfaction surveys provided evidence of satisfaction with the quality of care and services.
<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>	FA	<p>The quality and risk systems are understood by the staff. The risk and quality management systems cover the key components of service delivery. Quality data is collected through internal audits, staff and family satisfaction surveys, incidents and accidents and infection surveillance data. There is robust collation, analysis and trend reporting for the incidents and accidents, with less clearly documented analysis of medication errors and infection control data. Despite variability in the documentation of analysis and trending of quality data gathered, information is used to identify opportunities for improvement.</p> <p>The organisational policies and procedures are developed by an aged care consultant and have been personalised to the service. The policies are updated and reviewed at least two yearly or when there are changes to legislation or best practice. The policies were last reviewed in 2014. The policies include the organisational and RN responsibilities for the implementing and use of the interRAI assessment process. Only current versions of documents are available to staff. Staff sign to say that they have read the current policies.</p> <p>There is an audit scheduled which is adhered to. The family satisfaction survey identifies positive feedback about the care, services and environment. Where there are shortfalls noted in the internal audits, action plans are implemented. The results are fed back to staff through the staff meeting, memos and staff handovers. Audit results and any areas of concern are also discussed at the weekly management meeting. Corrective action planning includes the area that needs improving, how it is to be implemented, who is responsible and when this is completed. The corrective action form includes follow up review of the actions implemented to ensure these have been effective.</p> <p>Actual and potential hazards and risks are recorded in the hazard register. The hazards include clinical and business risks. There are also hazard identified forms for newly identified issues. The hazard register records a description of the hazard, possible remedies, actions taken and if the actions taken were effective in addressing the hazard or reducing the risk. Hazards that cannot be eliminated have ongoing monitoring. Risk minimisation strategies and fencing has been put around the construction site of a new building.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p>	FA	Staff and management understand their obligations in reporting serious harm. There

<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>have been no incidents that have required reporting to the required authorities.</p> <p>The incident and accident reporting systems records any adverse, unplanned, or untoward events. Staff understand when they are required to complete an accident/incident form. The service has conducted a quality improvement project into the accident/incident reporting system to reduce falls, challenging behaviour and use of antipsychotic medication for residents living in the dementia unit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>The validation of professional qualifications is maintained by the general manager. Current annual practising certificates were sighted for all health professional employed and/or contracted to the service.</p> <p>Human resources management processes implemented meet legislative requirements and are reflective of current good practice. Job descriptions were available for each position. All new staff are supported to integrate into their new work environment and their role through the orientation and induction process. This includes essential components of service delivery and the organisation's philosophy on the Spark of Life. Staff confirmed orientation allowed staff to undertake their role. Staff competencies are monitored by the clinical nurse manager, for example, medication competencies. The two of the RNs have completed their interRAI training. Annual performance reviews are conducted.</p> <p>The service providers support and facilitate training and education that is appropriate to the needs of the service and maintain records of the training provided. Training needs are also identified in the annual performance appraisal process. Education calendars and topics are provided to meet all obligations of the provider's residential care contract with the district health board (DHB) to provide rest home and dementia specific care. The Aged Care Education (ACE) programme, which include the dementia specific modules, is provided to staff. All staff who work in the dementia unit have completed or enrolled in the required dementia unit standards. Both on-site and off-site education is available for staff to attend.</p> <p>Residents, family members and the general practitioner confirmed the services provided are delivered to meet residents' needs.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>Policy identifies staffing levels and skill mix are to be maintained to meet residents' needs and to comply with the DHB's contractual requirements and safe staffing guidelines. Rosters identified that at all times there were adequate numbers of suitably qualified staff on duty to provide safe care in both the rest home and dementia unit. Staff were replaced when on annual leave or sick leave. There is a</p>

		<p>RN on call roster and an additional staff member that lives onsite that is available to assist after hours, for example, if additional assistance is required following a resident fall. There are appropriate numbers of administration, activities, maintenance/caretaker and housekeeping staff to meet the needs of the service and residents.</p> <p>The general manager reported that additional staff would be rostered to meet an increase in residents' needs. Staff confirmed there are adequate staff on each shift and that they have time to complete all tasks to meet residents' needs. Residents stated their needs are met in a timely manner. The family members reported satisfaction with the staffing and care provided.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>Medications for residents are received and delivered by the pharmacy in a pre-packed delivery system. A safe system for medicine management was observed on the day of the audit. Medicines were stored in a locked medicine trolley and stored in a locked room in the rest home and memory loss unit. The control medicines register was sighted and all controlled drugs currently stored on sight are in use.</p> <p>The 10 medicine charts reviewed have been reviewed by the GP every three months as was recorded on the medicine chart. All prescriptions sighted contained the date, medicine name, dose and time of administration. All medicine charts have each medicine individually prescribed and 'as required' (prn) medications identified had the reason stated for the use of that medication. There is a specimen signature register maintained for all staff who administers medicines. Medicine files reviewed have a photo of the resident to assist with the identification of the resident and recorded any medicine related allergies. The registered nurse reported that no residents are self-medicating.</p> <p>There are documented competencies sighted for the staff (registered nurse and caregivers) designated as responsible for medicine management. The registered nurse administering medicines at the time of audit demonstrated competency related to medicine management. The medicine competencies undertaken by current staff include specific insulin and warfarin instructions.</p> <p>There is a medication fridge in the rest home where insulin is stored. The registered nurse was able to tell show me the temperature gauge in the fridge and was aware of the importance and responsibility for the recording of the medication fridge temperatures. However temperature recordings for the medication fridge have not been recorded recently (Refer to criterion 1.3.13.5). All recordings were evidenced for the medication and kitchenette fridges in the memory loss unit.</p>

<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>PA Low</p>	<p>There is a four week rotating menu with summer and winter variations. The menu is created and reviewed by a dietitian. Where unintentional weight loss or weight gain is recorded, the resident is discussed with the GP and referred for a dietitian review.</p> <p>A nutritional profile is completed for each resident by the registered nurse upon entry to the service and this information is shared with the kitchen staff with a copy remaining in the kitchen to ensure all needs, wants, dislikes and special diets of the resident are catered for. The main kitchen in the rest home and kitchenette in the memory loss unit is available for staff to provide residents with food and nutritional snacks 24 hours a day.</p> <p>All meals are cooked and served directly from the kitchen at the time of the meal in the rest home. Residents are encouraged to have all meals in the dining area but have the option of eating meals in their rooms. The bain-marie is then transferred to the dementia unit to support meal service. Residents in the memory loss unit are encouraged and have the option to prepare and cook food with guidance and supervision of staff. Family/whanau and residents interviewed reported that they are very satisfied with the food and fluid services.</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 care plans reviewed in the rest home and memory loss unit were individualised, personalised and reflected the needs of each resident. Observations on the day of audit indicated residents are receiving care that is flexible and focused on promoting quality of life for the residents. The GP expressed satisfaction with the care provided and reported that the staff were knowledgeable and appropriately skilled. The registered nurses and caregivers interviewed reported that the care plans are accurate and kept up to date to reflect the resident's needs.</p> <p>Residents and family/whanau interviewed reported high satisfaction with the care and service delivery.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The activities programme incorporates the Spark of Life programme to empower the residents to be valued and respected. The residents are provided with opportunities that are of interest to them from the past and present and are encouraged and supported to maintain their community networking and friendships allowing for ongoing socialisation and developing new interests. The activity coordinators adapt activities to meet the needs and choices of the resident.</p> <p>The daily and monthly activities plan sighted was developed based on the residents' needs, interests, skills and strengths. A monthly calendar is delivered to each resident in their room and different activities discussed that may be of interest to</p>

		<p>them specifically.</p> <p>The activities programme covers cognitive, physical and social needs. The activities are modified to suit the individual needs and capabilities of each resident. There are group and individual activities that focus on sensory activities and reminiscence and events that are organised within the township. Regular activities include the reading and discussing of current affairs, different church services, daily exercise, van outings, specific women's and men's groups, arts and crafts, 'happy hour' once a month and regular weekly entertainment.</p> <p>The service provides easy access to outside areas that enable the resident to wander safely.</p> <p>Residents' files reviewed have activities and social assessments that identify the resident's individual diversional, motivational and recreational requirements over a 24 hour period. The goals are updated and evaluated in each resident's file three monthly. The family/whanau interviewed reported that their relative enjoys the range and variety of planned activities. The activities coordinator reported that residents and families are encouraged to complete a social history on admission which supports the staff to individualise the activities care plan.</p> <p>The memory loss unit has an activities coordinator who works full-time Monday to Friday 11am – 4pm. The rest home has an activities coordinator Monday-Friday 0930-1230. Caregivers interviewed report that activities are accessible for all staff in the evenings and weekends as required. The activity coordinator based in the memory loss unit has completed training in 2014 and is a Spark of Life practitioner and attends a two monthly community diversional therapy meeting.</p> <p>Memory loss unit: Family members of two residents interviewed reported they are welcome and supported with visiting their family member and encouraged to partake in planned activities. Residents have access to a home like kitchen setting environment within the unit and residents are encouraged, supported and supervised by staff and family to maintain daily activities of living.</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>Evaluations are documented at least six monthly. When there are short term care plans, these interventions are evaluated more frequently. The wound treatment plan sighted has an evaluation of the treatment and condition of the wound at each dressing changes. Short term plans are sighted for wound care, infections, changes in food and fluid intake, skin care and changes in mobility. If a resident is not responding to the services/interventions being delivered, or their health status changes, then this is discussed with their GP. All the longer term care plans sighted</p>

		<p>were developed, reviewed and evaluated in the last six months.</p> <p>The residents and family/whanau reported high satisfaction with the care provided at the service and stated that they can consult with the staff at any time if they have concerns or there are changes in the resident's condition.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The current building warrant of fitness were displayed for the both the rest home and dementia unit buildings. Since the last audit the service has converted an office area in the rest home to add an extra resident's room, increasing the rest home to 17 beds. The room is of a suitable size, location and has windows for light and ventilation. This changes has not affected the layout of the building tor required changes to the approved evacuation plan.</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 service conducts monthly surveillance for infections. The service uses standardised definitions of infections that are appropriate to the long term care setting. The monthly analysis of the infections includes comparison with the previous month, reason for increase or decrease and actions taken to reduce infections. Trends are identified and these are discussed at staff meetings and at staff handovers where additional actions are discussed and implemented.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There were no restraints or enablers in use at the service at the time of audit. This is also confirmed by observations and the internal audit on restraint minimisation confirmed the service provides a restraint free environment. The policies identify that if enablers are to be used, these would be voluntary and the least restrictive option to maintain resident independence and safety. The staff demonstrated knowledge on the strategies implemented to maintain a restraint free environment.</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)
<p>Criterion 1.3.13.5</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.</p>	PA Low	<p>The kitchen and food policy states that food handling areas and practices will meet the requirements of the Food Act 1981. It includes guidelines for cleaning with a separate cleaning schedule, temperature requirements, hygiene standards for staff, purchasing of food, checking, storage and waste handling. Regular monitoring and surveillance of food preparation and hygiene is carried out. Food procurement, production, preparation, storage, delivery and disposal was also sighted at the time of audit. Fridge, freezer and bain-marie recordings have not been recorded since June 2015. Kitchen staff have undertaken food safety management education appropriate to service delivery. Kitchen staff stated that they visually check the temperatures for the fridges, freezers and bain-marie in the kitchen daily. Residents reported that they receive their meals hot; however no temperatures</p>	<p>No fridge, freezer or bain-marie temperature recordings in the kitchen have been recorded since June 2015 of the three freezers and three fridges and one bain-marie associated with the kitchen and the medication fridge in the rest home.</p>	<p>Provide evidence of temperature recordings to comply with current legislation and guidelines.</p> <p>180 days</p>

		have been documented. Fridge temperature recordings recorded and evidenced for the food and medicine fridge in the memory loss unit.		
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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.