# Lakewood Rest Home 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 Health and Disability Auditing New Zealand 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Lakewood Rest Home Limited

**Premises audited:** Lakewood Rest Home

**Services audited:** Dementia care

**Dates of audit:** Start date: 10 December 2015 End date: 10 December 2015

**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:** 33

# 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 |
|  | 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

Lakewood Rest Home provides dementia level care for up to 36 residents and on the day of the audit there were 33 residents. An experienced owner/manager, who is a registered nurse, manages the service. The relatives interviewed all spoke positively about the care and support provided.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with family, management and staff.

The service has addressed seven of the ten shortfalls from the previous certification audit around consent processes; policy reviews; care documentation; nursing assessments; activities plans; aspects of medication management; and calibration of medical equipment. Improvements continue to be required in relation to communicating quality results to staff; aspects of medication management and aspects of food services.

This surveillance audit identified that improvements are required in relation to staff training.

## Consumer rights

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| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | Standards applicable to this service fully attained. |

Residents and family report that they are kept informed. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service.

## Organisational management

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| 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. |

The owner/manager is a registered nurse who is supported clinically by two additional registered nurses. The quality and risk management programme includes a service philosophy, goals and a quality and risk management programme. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and investigated.

An education and training programme has been implemented with a current plan in place. Appropriate employment processes are adhered to.

A roster provides sufficient and appropriate cover for the effective delivery of care and support.

## Continuum of service delivery

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| 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 medium or high risk and/or unattained and of low risk. |

Initial assessments, care plans and evaluations are completed within the required timeframes by a registered nurse, with evidence of family participation. Care plans are written in a way that enables all staff to clearly follow their instructions.

Planned activities are appropriate to the residents' interests. Families interviewed confirmed their satisfaction with the programme. The activities programme reviewed supports the interests, needs and strengths of residents. Individual activities are provided either within group settings or on a one-on-one basis.

Staff responsible for medicine management have attended in-service education for medication management. The provider implements systems to safely manage medication administration, review, storage and disposal.

All food is cooked on site. Relatives interviewed confirmed satisfaction with food services. The menu is varied and appropriate. Individual and special dietary needs are catered for.

## Safe and appropriate environment

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| 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. |

A current building warrant of fitness is posted in a visible location.

## Restraint minimisation and safe practice

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| 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. |

Restraint minimisation and safe practice policies and procedures are in place. Staff receive training in restraint minimisation and challenging behaviour management. On the day of audit there were no residents using restraint or enablers.

## Infection prevention and control

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| 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. |

The infection prevention and control programme aims to prevent the spread of infection and reduce the risks to residents, staff and visitors. The surveillance programme is appropriate for the size and nature of the services provided. Results of surveillance are acted upon, evaluated and reported to staff in a timely manner.

## Summary of attainment

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

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| **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 | 15 | 0 | 3 | 1 | 0 | 0 |
| **Criteria** | 0 | 39 | 0 | 3 | 1 | 0 | 0 |

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| **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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

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| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.10: Informed ConsentConsumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Informed consent processes are discussed with families on admission. Discussion with family members identified that the service actively involves them in decisions that affect their relative’s lives. Five of five residents’ files sampled have a signed admission agreement and written general consents. Findings from the previous audit have been addressed. |
| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.  | FA | The complaints policy describes the management of the complaints process. Complaints forms are available. Information about complaints is provided on admission. Interviews with families demonstrated their understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints.Complaints for 2015 to date were reviewed. All three complaints reviewed included an investigation and met timelines determined by the Health and Disability Commissioner (HDC). One complaint received in December is under investigation. Missing was evidence of complaints being collated and analysed with staff being kept informed (link to finding 1.2.3.6). Discussions with residents and relatives confirmed that any issues are addressed and that they feel comfortable to bring up any concerns.  |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | All eight families interviewed stated they were welcomed on entry. Families and residents are given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alert staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. All families confirmed they are notified of any changes in their family member’s health status. The incident/accident form includes a section to record family notification, which was completed in all fifteen incident/accident forms reviewed. An interpreter policy is in place. Interpreter services are available. The owner/manager reports that external interpreter services have not been required. |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Lakewood Rest Home provides dementia specific care for up to 36 residents with occupancy of 33 residents on the day of the audit. The manager who is a registered nurse (RN) privately owns the facility. A registered nurse, a supervisor/senior caregiver and 32 staff support the manager. The business plan for 2015 – 2016 includes a mission statement; philosophy; and operational goals and objectives. The philosophy of the service includes providing safe and therapeutic care for residents with dementia that enhances their quality of life and minimises risks associated with their confused states. Goals are regularly reviewed by the manager and are discussed at the monthly staff meetings. The owner/manager has maintained a minimum of eight hours of professional development relating to managing an aged care service.  |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low | A 2015 quality and risk management programme is developed for the service. Interviews with the owner/manager and staff reflect their understanding of the quality and risk management systems. Policies and procedures, and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. A document control system is in place with evidence to support policies being reviewed annually. This is an improvement from the previous audit. Policies include reference to InterRAI for an aged care service. Quality data is collected, trended, and analysed and results are communicated to staff, although complaints received are not collated and analysed and staff are not kept informed regarding complaints received. This previous area identified for improvement remains.An internal audit programme is in place. Corrective actions are being documented where improvements are indicated. Corrective actions are being implemented with the owner/manager signing them following implementation. An annual risk management plan is in place. A health and safety programme is being implemented including an up-to-date hazard register and a process for managing and controlling identified hazards. Falls prevention strategies include an investigation of residents’ falls on a case-by-case basis to ensure that strategies to reduce falls have been implemented.  |
| Standard 1.2.4: Adverse Event Reporting 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.  | FA | There is an accidents and incidents reporting policy. Accidents and incidents are documented on a separate accident/incident form. Fifteen accident/incident reports were selected for review. Adverse clinical events are investigated by a registered nurse, with links to the residents’ care plans. Neurological observations are conducted for unobserved falls and falls with suspected injury to the head.Discussions with the owner/manager confirmed his awareness of the requirement to notify relevant authorities in relation to essential notifications.  |
| Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.  | PA Low | There are human resource management policies in place, which includes the recruitment and staff selection process. Relevant checks are completed to validate the individual’s qualifications, experience and veracity. Copies of practising certificates were sighted. Five staff files were reviewed. Signed employment contracts were sighted with job descriptions included in the employment contract. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. There was evidence of completed orientation programmes in all five staff files reviewed. The owner/manager completes annual performance appraisals. The in-service education programme for 2015 is being implemented and includes a minimum of eight hours of mandatory training per year. All three RNs are trained in InterRAI. Two caregivers who have been employed for over one year have not completed their dementia qualification.  |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | A staff rationale and skill mix policy is in place. Sufficient staff are rostered on to manage the care requirements of the residents. One RN is rostered on-site for a minimum of six days a week. An RN is always on call if not on-site. Additional staff are rostered for increased residents' requirements. Interviews with staff and family members identify that staffing is adequate to meet the needs of residents. |
| 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 Moderate | Registered nurses and caregivers responsible for administering medication complete annual medication competencies and attend annual medication education. The service uses individualised robotic packs for regular and ‘as required’ (PRN) medications. Ten medication charts were reviewed on the day of the audit. The medication trolley contained PRN medications and eye drops that were expired and eye drops which were not dated on opening. Medication charts were not consistently reviewed at least three monthly by the GP. It was not evidenced that all medication was given as prescribed by the GP. It was not evidenced that a controlled medication administered, was recorded on the signing sheet.A weekly stock check of controlled medications was evidenced in the controlled medication book. The key to the controlled medication safe was observed to be with a medication competent staff member at all times during the audit. The temperature of the medication fridge was recorded weekly. There was no medication observed at audit that had been administered without a GP prescription. The service has addressed these aspects of the previous finding. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | PA Low | The service employs two cooks, one of whom works each day. Two kitchen hands support them daily. There is a four weekly seasonal menu in operation. On interview, the cook confirmed that the menu is reviewed and approved by a dietitian. The cook receives a resident dietary profile for all new admissions and notified of dietary changes. Resident likes, dislikes and dietary preferences were known and were displayed on a board. The kitchen is able to meet the needs of residents who require special diets and the cook works closely with the RN on duty. Temperature monitoring is not occurring as per current best practise. Labelling of food in the pantry was not evidenced. This remains a finding from the previous audit. There is special equipment available for residents if required. Staff were observed sitting with the residents when assisting them with meals. There are snacks available over 24 hours. Family members interviewed were satisfied with the quality and variety of food served.A cleaning schedule is maintained. Staff were observed wearing aprons and gloves but hair was not covered while staff were preparing food. Chemicals were stored safely in the kitchen. A food dish for a cat was sighted on the floor of the kitchen.  |
| Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Assessment templates were comprehensively completed in the sample of residents’ files reviewed. Risk assessments have been completed on admission and reviewed six monthly as part of the care plan review for those residents that have been at the service for six months. All outcomes of assessments were reflected in the residents’ long-term care plans. InterRAI assessments are completed and there are three RNs trained. All files reviewed included an individual assessment that included identifying diversional, motivation and recreational requirements including interventions for behaviours. There were comprehensive wound assessments in place for all wounds reviewed. The previous findings relating to wounds, behaviour and initial assessments have been addressed. |
| Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | The long-term care plans reviewed described the support required to meet the resident’s goals and need. This includes behaviour management strategies, which cover a 24-hour period. Residents and their family/whānau are involved in the care planning and review process. The long-term care plans reviewed were updated for both long-term and short-term changes in health status. Staff interviewed reported they found the plans easy to follow. The previous finding relating to the activities plan has been addressed. |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | All residents’ files reviewed evidence and record interventions that are consistent with the residents’ identified needs and desired goals set. Monitoring forms are completed as directed by the care plan. These include, but not limited to behaviour, weights and glucose monitoring. Interviews with RN and caregivers demonstrated an understanding of the individualised needs of residents.Wound assessments were in place for the two wounds reviewed. One wound was a burn and the other was a skin tear. Monitoring and wound management plans were in place for both wounds. There were no pressure injuries. All wounds have been reviewed in appropriate timeframes. The RNs have access to specialist nursing wound care management advice through the district nursing service.The service has adequate dressing and continence supplies to meet the needs of the residents. Continence assessments were sighted in all of the residents’ files. The general practitioner interviewed expressed satisfaction with the care given to the residents. |
| Standard 1.3.7: Planned ActivitiesWhere 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. | FA | There are two qualified diversional therapists (1.8 full time equivalents) employed six days a week. Caregiver staff assist when activities staff are not available. The seven-day programme includes daily tasks such as laundry folding, gardening and cleaning tasks. Each resident file sampled had an individual activities assessment on admission. An individual activities plan covering 24 hours was developed as part of the care plan in the residents’ files reviewed. This is evaluated at least six monthly when the care plan is evaluated. Each resident is free to choose if they wish to participate in the group activities programme or their individual plan. Participation is monitored. Families interviewed commented positively on the activity programme.  |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | A registered nurse evaluates all initial care plans within three weeks of admission. The long-term care plan is evaluated at least six monthly or earlier if there is a change in health status. All changes in health status are documented and followed up. An RN signs care plan reviews. Short-term care plans are evaluated and resolved or added to the long-term care plan if the problem is ongoing as sighted in residents’ files sampled. Where progress is different from expected, the service responds by initiating changes to the care plan.  |
| Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness is posted in a visible location (expiry 1 June 2016).New medical equipment has been purchased over the past year including sitting scales, and a sphygmomanometer. The calibration of this new equipment is scheduled for January 2016. This is an improvement from the previous audit. |
| Standard 3.5: SurveillanceSurveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Infection surveillance and monitoring is an integral part of the infection control programme and is described in policy. The registered nurse is the designated infection control coordinator. Monthly infection data is collected for all infections based on signs and symptoms of infection. Surveillance of all infections is entered on to a monthly resident infection data sheet, then analysed and evaluated, and reported to staff meetings.  |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | There is a restraint minimisation programme in place applicable to the type and size of the service. Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. The policies and procedures include definitions, processes and use of restraints.There were no residents using enablers or restraints during the audit. Staff training around restraint minimisation and enablers is in place. |

# 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.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.3.6Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Low | Adverse event data (eg, falls, skin tears, staff accidents, infections, internal audit results) is collected. Data collected is collated, analysed and results are communicated to staff although this process has not been implemented for complaints received.  | Complaints received have not been collated and analysed to identify potential service improvements. Staff are not kept informed regarding complaints received.  | Ensure complaints received are collated and analysed, and that staff are kept informed regarding complaints received.90 days |
| Criterion 1.2.7.5A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Low | An education and training programme is in place for staff with evidence of monthly in-services. In addition, opportunistic education is provided. Discussions with staff and the owner/manager confirmed that an education and training programme in relevant aspects of care and support is in place with support provided by the Canterbury District Health Board. Missing is evidence of all caregiver staff who have been employed for over one year holding evidence of a qualification in dementia care. | Fifteen caregivers are regularly rostered with eight caregivers employed for over one year. Two of the eight caregivers are enrolled in the Aged Care Education (ACE) dementia course but have not completed their required dementia qualification. The remaining seven caregivers are enrolled.  | Ensure all caregivers who have been employed for over one year have completed a qualification in dementia education.90 days |
| Criterion 1.3.12.1A 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. | PA Moderate | The service has a medication policy. Medications are checked on delivery against the medication chart and administered as prescribed. Medication administration was observed to be compliant. ‘As required’ medications have the date and time of administration on the signing sheet. Seven charts reviewed had been reviewed by GP at least three monthly. Eye drops were observed not dated on opening. Expired medication was observed in the medication trolley. There were gaps in the signing sheet in five of ten medication charts. Three charts reviewed had medication given as prescribed by GP.  | i) Expired medications were observed in the medication trolley, ii) Three eye drops were not dated on opening, iii) Three charts reviewed had not been consistently reviewed three monthly by the GP, iv) Five files reviewed had gaps in the signing sheet including one controlled medication, and v) Seven charts documented medications not given as prescribed. | i) Ensure all expired medication is returned to pharmacy, ii) Ensure all eye drops are dated on opening, iii) Ensure all medication charts are reviewed at least three monthly by the GP, iv) Ensure that all medication is recorded when administered or a reason for non-administration is stated and v) Ensure all medications are administered as prescribed. 30 days |
| Criterion 1.3.13.5All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines. | PA Low | There is a food services manual in place to guide staff. The kitchen staff have completed food safety training. The temperatures of refrigerators, freezers and cooked foods are only recorded monthly. All foods in the fridge were dated and labelled. Decanted dry goods in the pantry were not labelled with expiry or best before dates. There was evidence that a cat was being fed on the floor in the kitchen. Hats were not being worn in the kitchen whilst food was being prepared. There was no evidence that resident care was being compromised so the risk is considered low. | i) Temperature of cooked food was only being recorded at least monthly. ii) Fridge and freezer temperatures were only being recorded at least monthly. iii) Dry goods in the pantry had been decanted into containers with no evidence of the best before or expiry date of those foods. iv) Staff were observed preparing foods without wearing a hat. v) A cat bowl with cat food in it was observed on the kitchen floor. This was removed on the day of the audit. | i) Ensure the temperature of cooked foods are recorded daily, ii) Ensure fridge and freezer temperatures are monitored daily and recorded weekly, iii) Ensure that all decanted dry goods are labelled with the expiry or best before date of the food, iv) Ensure that all persons in the kitchen cover their hair when food is being prepared and v) Ensure that no animals are allowed access to the kitchen at any time.90 days |

# 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, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

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End of the report.