

Home of St Barnabas Trust

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](#).

The specifics of this audit included:

Legal entity:	Home of St Barnabas Trust
Premises audited:	Home of St Barnabas
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 16 December 2016 End date: 16 December 2016
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:	39

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

The Home of St Barnabas provides rest home level care for up to 41 residents and on the day of the audit there were 39 residents. The service is managed by a manager/registered nurse. The residents and 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 resident and staff files, observations and interviews with residents, family members, staff and management.

The service has addressed all four of the shortfalls from the previous audit around the complaint process, staff documenting their designation and dating reports, long-term care plans, and food, fluid and nutritional needs of residents.

This audit identified that improvements are required around communicating quality results to staff, corrective action plans, reference checking potential employees, staff training, accident and incident reporting, pressure injury management plans and recording fridge 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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Families interviewed reported that they are kept informed. A system for managing complaints is in place. The right of the resident and/or their family to make a complaint is understood, respected and upheld by the service.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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The service is governed by a board of trustees. Services are planned, coordinated and are appropriate to the needs of the residents. The manager/registered nurse is responsible for the day-to-day operations. Quality and risk management processes are established. Quality goals are documented for the service. A risk management programme is in place, which includes a risk management plan, incident and accident reporting, and health and safety processes. The health and safety programme meets current legislative requirements.

An orientation programme is in place for new staff. A staff education and training programme has been established. Registered nursing cover is available twenty-four hours a day, seven days a week. There are adequate numbers of staff on duty to ensure residents are safe. Information management systems meet requirements of the standard.

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 registered nurses are responsible for the assessments, care plan development and evaluations. The InterRAI assessment is being utilised to inform the care plans. Risk assessment tools and monitoring forms are available. Care plans demonstrate service integration. Care plans are evaluated six monthly or more frequently when clinically indicated. The general practitioner reviews the residents at least three monthly.

A diversional therapist provides an activity programme to meet the needs of residents. Each resident has an individualised plan. Residents are encouraged to participate in community activities. There are regular drives and outings for residents.

The medication management system follows recognised standards and guidelines for safe medicine management practice. Staff responsible for administering medications complete annual competency assessments.

Meals are prepared in the kitchen by qualified cooks. Individual and special dietary needs and dislikes are accommodated. Residents interviewed responded favourably about the food that was provided.

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

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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Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint. Policy is aimed at using restraint only as a last resort. Staff receive regular education and training on restraint minimisation. No restraints or enablers were in use.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator (registered nurse) is responsible for collating infection control data and communicating information to the management and staff. The infection control coordinator uses the information obtained through surveillance to determine infection control activities and education needs within the facility.

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	13	0	5	0	0	0
Criteria	0	34	0	7	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
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints procedure is provided to residents and families during entry to the service. Access to complaints forms are located at reception. The complaints process is linked to advocacy services.</p> <p>A record of complaints received is maintained using a complaints register. Six complaints were received (year-to-date) in 2016. Timeframes for responding to complaints meet requirements set forth by the Health and Disability Commissioner (HDC). All six complaints reviewed reflected evidence of acknowledgement, an investigation and resolution. This is an improvement since the previous audit. Complainants are kept informed throughout the complaints process.</p> <p>Discussions with eight residents and families confirmed they were provided with information on the complaints process and remarked that any concerns or issues they had were addressed promptly.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to</p>	FA	<p>The open disclosure policy is based on the principle that residents and their families have a right to know what has happened to them and to be fully informed at all times. The care staff interviewed (five caregivers, two registered nurses, one activities coordinator) understood about open disclosure and providing appropriate information and resource material when required.</p> <p>Two family members interviewed confirmed they are kept informed of the resident's status, including any events adversely affecting the resident. Ten accident/incident forms reviewed reflected documented</p>

effective communication.		<p>evidence of families being informed following an adverse event (link to finding 1.2.4.3).</p> <p>An interpreter service is available and accessible if required through the district health board. Families and staff are utilised in the first instance.</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 Home of St Barnabas Trust was incorporated as a Charitable Trust under the Charitable Trusts Act 1957 in 2003 by the Anglican Diocese of Dunedin. The Trust is governed by a board of trustees. The home is certified to provide rest home level care for up to 41 residents. On the day of audit, there were 39 residents. There was one resident on respite.</p> <p>The purpose, values, scope, direction, and goals of the organisation are clearly identified. Goals are regularly reviewed.</p> <p>The service is managed by an experienced manager/registered nurse with a current practising certificate. The manager has been in the role for 20 years. She is supported clinically by a team of four registered nurses. She has completed over eight hours of professional development relating to the management of an aged care facility.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	PA Low	<p>A quality and risk management system is established that is understood by staff as confirmed during interviews with the manager and staff (eight care staff, one house supervisor, and one cook). Policies and procedures align with current good practice and meet legislative requirements. Policies have been updated to reflect processes around InterRAI and pressure injuries. They are regularly reviewed as per the document review schedule. New policies and updates to existing policies are discussed in staff meetings as evidenced in the monthly staff meeting minutes.</p> <p>Quality management systems are linked to internal audits, incident and accident reporting, health and safety reporting, infection control data collection and complaints management. Data is collected and analysed for a range of adverse event data (link to finding 1.2.4.3). Results are not routinely shared with staff. Where improvements are identified, corrective actions are documented but documentation does not indicate that corrective actions are evaluated and signed off when completed.</p> <p>Examples of quality initiatives were evidenced including (but not limited to) the implementation of a new call bell system and the introduction of an electronic medication management system.</p> <p>A risk management plan is in place. Health and safety policies have been reviewed since the new legislation has come into effect. An interview was conducted with a health and safety representative who has attended stage one health and safety training. Staff receive health and safety training, which begins during their induction to the service. All staff are involved in health and safety, which is a regular topic in</p>

		<p>the monthly staff meetings. Actual and potential risks are documented on the hazard register, which identifies risks and documents actions to eliminate or minimise the risk.</p> <p>Falls management strategies include sensor mats, and the development of specific falls management plans to meet the needs of each resident who is at risk of falling.</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>	PA Low	<p>There is an incident reporting policy that includes definitions and outlines responsibilities. Incident/accident data is linked to the organisation's quality and risk management programme (link to findings 1.2.3.6 and 1.2.3.8). Ten accident/incident forms were reviewed. Each event involving a resident reflected a clinical assessment and follow-up by a registered nurse. Neurological observations were conducted for suspected head injuries. Missing was evidence of staff completing an accident/incident form for pressure injuries.</p> <p>The manager is aware of her responsibility to notify relevant authorities in relation to essential notifications.</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>	PA Low	<p>Human resources policies are in place, including recruitment, selection, orientation and staff training and development. Five staff files were reviewed (one RN, four caregivers). Four of five staff files contained evidence of the recruitment process although were missing evidence of reference checking. Signed employment contracts and evidence of a completed orientation programme were sighted. The orientation programme provides new staff with relevant information for safe work practice. Competencies are completed specific to worker type. Staff interviewed stated that they believed new staff were adequately orientated to the service.</p> <p>A register of current practising certificates for all health professionals is maintained.</p> <p>There is an annual education schedule that is being implemented. Staff training hours failed to reflect a minimum of eight hours of training per care staff. One of four RNs has completed InterRAI training and one is currently completing interRAI training.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled</p>	FA	<p>The staffing policy aligns with contractual requirements. The manager is an experienced RN who works Monday - Friday. Staffing hours are flexible to meet the level of acuity of the residents. Two RNs are rostered on the am shift, Monday – Friday, totalling 12 hours. RNs share a call roster for the remainder, providing 24/7 RN cover.</p> <p>There are adequate numbers of caregivers available with a minimum of two caregivers scheduled during</p>

and/or experienced service providers.		the night shift. There are separate cleaning and laundry staff. Activities staff work five days a week. Interviews with staff, residents and families confirmed staffing overall was satisfactory.
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	The resident files are appropriate to the service type. Five residents' files reviewed were integrated and included GP assessment and reviews. There is evidence of external health professional involvement where relevant. Care plans and notes reviewed were legible. Designation of the person who completed the entry documentation was recorded and nutritional assessments have the completed date on them. This is an improvement from the previous audit.
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. Registered nurses and medication qualified caregivers administer medications and have completed annual medication competencies. An electronic medication system is in use. The service uses four weekly blister packs which are checked against the medication chart by an RN. All medications are stored safely. There was one resident self-medicating an inhaler on the day of audit. The resident was competency assessed with three-monthly reviews and the medication was stored in a locked drawer. Standing orders are not used.</p> <p>Ten medication charts were reviewed. All medication charts had photo identification and allergy status documented. Prescribing of regular and 'as required' medication met legislative requirements. All medication charts had been reviewed by the GP at least three monthly. Administration signing sheets corresponded with the medication chart.</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>	PA Low	<p>All meals and home baking is prepared and cooked on-site. There are four cooks (including the kitchen supervisor) and a number of kitchenhands and servers. These staff are also responsible for meals preparation for a meals on wheels service. Food services staff have completed food safety hygiene training. There is a five-weekly menu that has been reviewed by a dietitian. The kitchen supervisor receives residents' dietary profiles that include resident dislikes and special requirements. Dislikes are accommodated. The kitchen supervisor is notified of any changes to resident's dietary needs or residents with any weight loss. The previous findings around dietary profiles have been addressed.</p> <p>Main kitchen fridge and freezer temperatures are monitored daily and recorded. Kitchenette fridge temperatures are not consistently monitored and recorded. End cooked food temperatures are monitored</p>

		<p>and recorded daily.</p> <p>Residents interviewed commented positively on the meals provided.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>The long-term care plans include information from the assessment tools and outline objectives of nursing care. Residents and relatives interviewed confirmed their involvement in setting goals in the care planning process. Care plans are available to staff to guide in the care of the resident. Five of five files reviewed included detailed interventions to support the current needs of the residents. The previous finding has been addressed.</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>	PA Low	<p>Documentation reviewed and interviews with staff and residents identified that care is being provided consistent with the needs of residents. When a resident's condition changes, the RN initiates a GP referral. There was evidence in the progress notes and on the accident/incident forms that families were notified of any changes to their relative's health including (but not limited to) accidents/incidents (including pressure injury), infections, health professional visits and changes in medications.</p> <p>Dressing supplies were sighted and are readily available for use. Wound management policies and procedures are in place. Wound assessments and ongoing wound evaluations describe the treatment, frequency of change of dressings and evaluations of wounds. There were six residents with nine wounds (two chronic wounds, three lesions, two skin tears and two pressure injuries). The two stage-two sacral pressure injuries were facility acquired. The pressure injuries did not have full wound management documentation in place and had not been followed through the adverse event process (link to finding 1.2.4.3). The RNs interviewed described the process should they require assistance from a wound specialist.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified.</p> <p>Monitoring forms in place include (but not limited to) monthly weight, blood pressure and pulse, food and fluid charts, blood sugar charts and behaviour charts.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a</p>	FA	<p>The service employs an activities coordinator (qualified diversional therapist) Monday to Friday for 36.5 hours per week. A varied programme that is flexible to meet the needs of the rest home residents is in place. The activities coordinator allocates time to spend with residents one-on-one to encourage individual interests.</p>

<p>consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>A van is used for regular outings/drives into the community and attending social events.</p> <p>Residents and relatives provide feedback on the activity programme through verbal feedback and six monthly multidisciplinary meetings. Residents interviewed spoke positively about the activity programme.</p> <p>Activity assessments are completed soon after admission. Attendance sheets are maintained and a monthly report is written for each resident and the individual activity plan is reviewed six monthly.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Four long-term care plans reviewed had been evaluated six monthly by a registered nurse. Written evaluations have been completed and demonstrate relative/resident involvement in the care plan review. InterRAI assessments have been completed six monthly as part of the care plan review. The fifth resident file reviewed was under a respite care contract and not required to have a long-term care plan. There is at least a three-monthly review by the medical practitioner.</p>
<p>Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>A current building warrant of fitness is posted in a visible location (expiry 3 March 2017).</p>
<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.</p>	<p>FA</p>	<p>There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator (RN) collates information obtained through surveillance to determine infection control activities and education needs in the facility. Monthly infection control reports are provided and presented to the RN meetings. The monthly infection control data report including trends, analysis and corrective actions is made available to staff. Definitions of infections are in place appropriate to the complexity of service provided. Internal audits for infection control are included in the annual audit schedule. Systems in place are appropriate to the size and complexity of the facility.</p> <p>There have been no outbreaks for two years.</p>
<p>Standard 2.1.1: Restraint minimisation</p>	<p>FA</p>	<p>There are policies around restraint, enablers and the management of challenging behaviours. The service is restraint-free. Restraint minimisation is a regular agenda item at staff meetings. Staff receive training</p>

<p>Services demonstrate that the use of restraint is actively minimised.</p>		<p>around restraint minimisation and safe practice.</p> <p>The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers should this be required.</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 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	PA Low	<p>Quality data that is collected (eg, falls, bruising, infections, skin tears), is collated and analysed. The internal audit programme is being completed as per the schedule. Staff are not kept informed regarding internal audit results.</p>	<p>Internal audit results are not being communicated to staff as evidenced in the staff meeting minutes for 2016. The staff room noticeboard also did not indicate that staff are kept informed although the manager reported that at times audit results are posted in the staff room.</p>	<p>Ensure staff are kept informed regarding internal audit results.</p> <p>90 days</p>
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and</p>	PA Low	<p>Corrective actions (recommendations) are documented for the internal audits that identify substandard results but there is no evidence to confirm that the corrective actions have regularly been implemented and signed off.</p>	<p>Corrective actions are stated as 'recommendations' in the internal audit findings. Missing was evidence in four of eight internal audits in September and October 2016 to indicate that the recommendations were implemented, evaluated and signed off.</p>	<p>Ensure corrective actions are implemented and evaluated with sign-off when completed.</p>

implemented.				90 days
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	PA Low	An accident/incident form is completed for adverse events although staff were unaware that an accident/incident form was required to be completed when a pressure injury was identified.	Two registered nursing staff interviewed were not aware that an accident/incident form were required for pressure injuries. Two pressure injuries identified during the audit did not have a corresponding accident/incident form completed.	<p>Ensure an accident/incident form is completed for any pressure injury.</p> <p>90 days</p>
<p>Criterion 1.2.7.3</p> <p>The appointment of appropriate service providers to safely meet the needs of consumers.</p>	PA Low	The staff files reviewed contained an application form, and evidence of an interview and police vetting. Missing was evidence of reference checking. The manager reported that two references are checked prior to appointing an applicant but that this is not always being documented and retained in the staff files.	Four of five staff files failed to reflect evidence of reference checking.	<p>Ensure staff files contain evidence of reference checking prior to appointment.</p> <p>90 days</p>
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Low	The 2016 calendar year introduced a new online training programme for staff. Each course takes approximately one – two hours to complete. Staff training logs failed to consistently evidence staff completing the online training programme. Furthermore, evidence does not confirm that staff have attended the minimum requirement of eight hours per annum.	Staff training records were reviewed for sample of eight staff. Seven of the eight staff reflected fewer than eight hours per annum with attendance at two or fewer training sessions. The manager reported that a higher number of staff have completed the online training courses but that they are not regularly submitting their completed paperwork.	<p>As per the aged residential care contract, ensure staff complete a minimum of eight hours of professional development per annum.</p> <p>90 days</p>

<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>	<p>PA Low</p>	<p>Food procurement, production, preparation, storage in the main kitchen complied with current legislation and guidelines.</p>	<p>Recording of kitchen fridge/freezer temperatures was undertaken. Two fridges in kitchenettes containing food for residents were not consistently monitored and recorded. There was no monitoring occurring for one fridge and inconsistent monitoring of another.</p>	<p>Monitor regularly the temperatures of all fridges storing resident food/fluid.</p> <p>30 days</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Low</p>	<p>Documentation (assessment, wound management plan, monitoring and evaluation) was available for wounds. A shortfall was identified around documentation in relation to pressure injuries.</p>	<p>(i) There was no wound management plan, evaluation or progress recorded for a stage two pressure injury of the sacrum (identified 1 December 2016) (link rest home tracer) (ii) There was no wound management plan for a stage two pressure injury of the sacrum (identified 14 December 16).</p>	<p>Ensure wound assessments and evaluations are completed for pressure injuries.</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.