

# Pacific Haven (2015) Limited - Pacific Haven Residential Care

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## 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:** Pacific Haven Residential Care (2015) Limited

**Premises audited:** Pacific Haven Residential Care

**Services audited:** Rest home care (excluding dementia care)

**Dates of audit:** Start date: 26 March 2018 End date: 27 March 2018

**Proposed changes to current services (if any):**

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

# Executive summary of the audit

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## 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

Pacific Haven provides residential services for residents requiring rest home level care. The current directors (one of who is the nurse manager) have owned the service since October 2015 and both manage the facility full time. On the day of the audit there were 26 residents.

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 residents, family, management and staff.

Residents, the family member and the GP interviewed praised the service for the support provided.

The service has addressed two of four shortfalls from their previous audit around progress note documentation and medication management. Further improvements continue to be required around, care interventions and hot water temperatures.

This surveillance audit identified improvements are required around surveys, care plan evaluations, food service and staff education.

## 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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There is evidence of open disclosure practises being implemented and families reported they are well informed. The complaints process is implemented, and complaints and concerns are actively managed. Residents and families are aware of the complaints process. Staff interviewed were familiar with processes to ensure informed consent.

## 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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Pacific Haven has a current business plan that includes specific goals for 2018.

Organisational performance is monitored through a number of processes to ensure it aligns with the identified values, scope and strategic direction. The policies and procedures are appropriate to provide support and care to residents with rest home level needs and a documented quality and risk management programme is implemented. Incidents and accidents are appropriately managed.

Staff receive ongoing training and there is a training plan developed and commenced for 2018. Rosters and interviews indicate sufficient staff that are appropriately skilled with flexibility of staffing around client's needs.

## 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 medium or high risk and/or unattained and of low risk.
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The nurse manager is responsible for each stage of service provision. A registered nurse assesses and reviews each resident's needs, outcomes and goals at least six monthly. Care plans demonstrated service integration and included medical notes by the general practitioner and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and senior carers responsible for administration of medication, complete annual education and medication competencies. The medicine charts were reviewed by the general practitioner at least three monthly.

An activities coordinator implements the activity programme for the residents. The programme includes community visitors, outings and activities that meet the individual recreational, physical, cultural and cognitive abilities and preferences for the residents. Residents and families report satisfaction with the activities programme.

Residents' food preferences and dietary requirements are identified at admission. All meals and baking are cooked on-site. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met as required.

## Safe and appropriate environment

<p>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.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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The service has a current building warrant of fitness and records hot water temperatures.

## Restraint minimisation and safe practice

<p>Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.</p>		<p>Standards applicable to this service fully attained.</p>
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The organisation actively minimises the use of restraint. All staff receive training on restraint minimisation and management of behaviours that challenge. There are no residents using enablers and no residents using restraint.

## Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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Infections are reported by staff and residents and monitored through the infection control surveillance programme by the infection control officer (the enrolled nurse). Infections are monitored and evaluated for trends and discussed at staff meetings.

## 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)
<b>Standards</b>	0	10	0	5	2	0	0
<b>Criteria</b>	0	35	0	5	2	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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>A complaints policy and procedures have been implemented and residents and their family/whānau are provided with information on admission. Complaint forms are available at the key points throughout the service, which are easy to find. The residents and the family interviewed were aware of the complaints process and to whom they should direct complaints. The service has had one complaint in the time the current owners have been involved. The complaint was well managed and reflected evidence of responding to complaints in a timely manner with appropriate follow-up actions taken. Residents and the relatives advised that they are aware of the complaints procedure and how to access forms.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment</p>	FA	<p>Five residents (two rest home, one long term chronic health and one younger persons with a disability) interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. The two relatives interviewed stated they are informed of changes in health status and incidents/accidents. This was consistently confirmed on incident forms reviewed. The five residents also stated they were welcomed on entry and were given time and explanation about services and procedures. Resident meetings occur monthly and the directors have an open-door policy. Aged care residents and family are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The managers interact on an informal and formal basis daily with all residents as reported by the managers and confirmed by the residents and observation.</p>

<p>conducive to effective communication.</p>		<p>The service has policies and procedures available for access to interpreter services for residents (and their family). If residents or family/whānau have difficulty with written or spoken English, the interpreter services are made available.</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>	<p>PA Low</p>	<p>Pacific Haven provides residential services for people requiring rest home level care. On the day of the audit, there were 26 residents. Twenty are under the aged residential care contract, three are under long-term chronic conditions contracts and three are on younger persons with disability contracts. The organisation has two directors (who own the business). They have previous experience in aged care and have undertaken mentoring since purchasing the facility but have not had recent training. One director operates as a full time non-clinical manager and the other (a registered nurse) operates as the nurse manager full time.</p> <p>The goals and direction of the service are well documented in the 2018 business plan and the progress toward previous goals has been documented.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>PA Low</p>	<p>The manager facilitates the quality programme and ensures the internal audit schedules are implemented. The internal audit schedule is implemented. Corrective action plans are developed, implemented and signed off when service shortfalls are identified.</p> <p>Quality improvement processes are in place to capture and manage non-compliances. They include internal audits, hazard management, risk management, incident and accident, and infection control data collection and complaints management. All quality improvement data is discussed at monthly staff meetings.</p> <p>There are policies and procedures that are relevant to the various service types offered and all have been reviewed since the change of ownership.</p> <p>There is a current risk management plan. Hazards are identified and managed and documented on the hazard register. The hazard register has recently been updated and covers all areas relevant to aged care and risk levels and mediation actions. The manager is the designated health and safety officer and has completed training relating to this role. The training included information about the recent legislation changes and a new policy and practices have been implemented. Health and safety issues are discussed at every monthly staff meeting with action plans documented to address issues raised.</p> <p>A resident survey has not been conducted and analysed since May 2015, apart from a food survey which has not been analysed.</p> <p>Falls prevention strategies are in place for individual residents.</p>

<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>The accident/incident process includes documentation of the incident and analysis and separation of resident and staff incidents and accidents. Ten incidents sampled for December 2017 and January, February and March 2018, demonstrated appropriate documentation and clinical follow-up. Accidents and incidents are analysed monthly with results discussed at staff meetings.</p> <p>The management team are aware of situations that require statutory reporting. There have been no notifications made since the previous audit</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>PA Low</p>	<p>Five staff files sampled (the chef, an RN and three caregivers) demonstrated appropriate employment practices and documentation. Current annual practicing certificates are kept on file.</p> <p>The orientation package provides information and skills around working with residents with aged care and mental health related needs (most residents have mental health needs) and was completed in all staff files sampled.</p> <p>There is an annual training plan in place which is not fully implemented. All files sampled contained a current annual performance appraisal. Residents and the family interviewed state that staff are knowledgeable and skilled.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably</p>	<p>FA</p>	<p>There is a documented rationale for staffing the service. Staffing rosters were sighted and staff on duty to match needs of different shifts and needs of different individual residents. On morning shifts, the nurse manager (RN) works 9-5 with the support of a second RN 20 hours per week. The manager and two 7 to 2:45pm work as caregivers on the morning shift. The manager and nurse manager cover from 2:45 to 4pm. There are two caregivers working from 4pm to 11:15pm and one caregiver working the full night shift. The management team live close to the facility and are on call 24/7. There is an on-call system with a registered nurse (the nurse manager) available at all times.</p>

qualified/skilled and/or experienced service providers.		Staff, residents and family interviewed confirmed that staffing levels are adequate.
Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	All documentation sighted had the name, designation, date and time of the entry documented. This is an improvement since the previous audit.
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.	FA	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. Caregivers and RNs who administer medications have completed a practical and written medication competency. The pharmacist provides annual in-service on medication administration and medication management and education on an annual basis. Medications are checked on delivery against the medication chart by the RN as evidenced by RN signature on the blister packs. Standing orders are not used. One self-medicating resident had a self-medication competency completed and authorised by the GP. The resident's medication was all charted. There was no evidence of medications being administered that were not prescribed. This is an improvement since the previous audit. All medications were stored safely in a locked cupboard and the self-medicating resident had a locked drawer. The medication fridge is monitored daily as sighted in records reviewed.</p> <p>Ten medication charts reviewed had photo identification and an allergy status on the medication chart. The GP has reviewed the medication charts at least three monthly. The administration signing sheets reviewed identified all prescribed medications had been administered as prescribed.</p>
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's	PA Moderate	All meals at Pacific Haven are prepared and cooked on-site. The Monday to Friday qualified cook (City and Guild), is supported by a weekend cook. An afternoon caregiver is allocated to the tea service. A food control plan registered with the local council is being implemented. There is a five-weekly seasonal menu, which had not been reviewed by a dietitian since April 2015. Meals are served directly from the kitchen to residents in the adjacent dining room. Dietary needs are known with individual likes and dislikes accommodated. Dietary requirements, cultural and religious food preferences are met. Additional or modified foods such as pureed foods and diabetic

<p>individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>desserts are provided as required. Residents and family members interviewed were satisfied with the food and confirmed alternative food choices were offered for dislikes. The cook reported that this can include cooking up to five individual meals to meet individual likes and dislikes at any one meal.</p> <p>Fridge, freezer and end-cooked temperatures are monitored and recorded. Containers of food are labelled and dated. All perishable goods in fridges are date labelled. Food stored in the kitchen is safely managed but food stored in the basement can be accessed by insects, birds and potentially small animals. The dishwasher is checked regularly by a contracted service. A cleaning schedule is maintained.</p> <p>All food services staff have completed training in food safety and hygiene and chemical safety. Nutrition and safe food management policies define the requirements for all aspects of food safety.</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>PA Moderate</p>	<p>When a resident's condition alters, the registered nurse initiates a review and if required, GP or nurse specialist consultation. There is evidence that family members were notified of any changes to their relative's health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications. Discussions with families and notifications are documented in the resident files reviewed. The GP and community psychiatric services have developed action plans for staff to follow in the event of declining medical and/or mental health well-being. Person-centred care plans include early warning signs and symptoms as relevant, but care plans do not address all assessed needs. This remains an area for improvement.</p> <p>Adequate dressing supplies were sighted. Wound management policies and procedures are in place. There is access to a wound nurse specialist from the DHB if required. There were no wounds at the time of the audit.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified.</p> <p>Monitoring occurs for blood pressure, weight, vital signs, blood glucose, pain and challenging behaviours. All monitoring forms were appropriately completed.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their</p>	<p>FA</p>	<p>The service employs an experienced activities coordinator who was on leave at the time of audit. In her absence the activity programme is being managed by the management team and caregivers. The activity coordinator attends regular DT support group meetings. The activity coordinator attends on-site in-service's and has a current first aid certificate.</p> <p>The Monday to Friday programme is provided from 9.00 am to 4.00 pm daily. Activities provided are appropriate to the needs, age and culture of the residents. Activities include spontaneous outings that occur in a normalised process when one of the managers is required to go out and residents join them. Examples include grocery shopping and hardware stores. The activities are meaningful and include (but are not limited to), newspaper</p>

<p>needs, age, culture, and the setting of the service.</p>		<p>reading, walks, housie, pet visits, music and word games. Activities are often spontaneous and the programme flexible, to meet the resident's preferences. The service has a van which includes weekly shopping trips, mystery drives, Saturday outings to MacDonald and visits to Orana Park. Community links and social interaction is maintained through community friendship groups, card groups and inter-home visits. A volunteer is involved with activities. There are on-site church services and regular visits from catholic nuns. The smoking reduction programme for residents continues with variable outcomes. The project continues but is now focusing on reducing risk while still meeting the resident's individual preferences. Previously residents had smoked in inappropriate areas. Changes implemented include facilitate a social area with staff supervision for residents that smoke to reduce the incidence of residents smoking in inappropriate areas alone.</p> <p>A resident diversional therapy profile is completed on admission. Each resident has an individual activity plan, which is reviewed six monthly as part of the six-monthly multidisciplinary review.</p> <p>Families are invited to the monthly resident meetings. The service receives feedback on activities through one-on-one feedback, and resident meetings. Residents interviewed stated the they enjoyed the activity programme.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>PA Low</p>	<p>All initial care plans reviewed were evaluated by the nurse manager/RN within three weeks of admission. Files sampled demonstrated that the long-term care plan was evaluated at least six-monthly or earlier if there is a change in health status. Reassessments have been completed using interRAI LTCF and other relevant assessment tools for residents who have had a significant change in health status. Short-term care plans sighted were evaluated and resolved or added to the long-term care plan if the problem is ongoing, as sighted in resident files sampled. Written evaluations did not identify if the desired goals had been met or unmet. The GP reviews the residents at least three monthly or earlier if required.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>PA Low</p>	<p>The building has a current building warrant of fitness that expires 1 April 2018. The facility is two levels, with the laundry and storage areas downstairs.</p> <p>Improvements to the building since the previous audit included: Shower and toilet refurbishment and several rooms updated with new carpet. Non-slip vinyl had been installed in the wet areas of one wing. The electrics have been replaced in the kitchen. There is a new emergency and a new call bell system. All rooms now have a wall mounted television.</p> <p>Hot water temperatures continue to be above 45 degrees Celsius in two areas. This previous shortfall is yet to be addressed.</p> <p>The caregivers interviewed stated they have sufficient equipment including hi-lo beds and pressure injury resources to safely deliver the cares as outlined in the resident care plans.</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>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 person. Individual infection report forms are completed for all infections and are kept as part of the resident files. Monthly infection data is collected for all infections based on signs and symptoms of infection. Surveillance of all infections is entered onto a monthly summary and then analysed and reported to staff meetings. There is close liaison with the GPs and laboratory service that advise and provide feedback and information to the service. Systems in place are appropriate to the size and complexity of the facility</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service philosophy includes that restraint is only used as a last resort. There were no residents at the time of the audit using restraint or enablers. The restraint policy includes a definition of enablers as voluntarily using equipment to maintain independence such as a lap belt in a wheelchair.</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 1.2.1.3</p> <p>The organisation is managed by a suitably qualified and/or experienced person with authority, accountability, and responsibility for the provision of services.</p>	PA Low	The managers have owned Pacific Haven for three years and have previously used the services of a mentor. They have not recently completed any management related training.	The two managers have not completed eight hours of training related to managing an aged care service.	<p>Ensure the manager completes eight hours of training related to managing an aged care service.</p> <p>90 days</p>
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results</p>	PA Low	Quality activities, including internal audits and analysis of incidents and infections occur as planned, but resident surveys have not been completed.	Resident/relative surveys have not been completed since May 2015 apart from a specific food service survey in November 2017, which has not been analysed.	Ensure resident surveys occur as scheduled and that the results are

communicated to service providers and, where appropriate, consumers.				analysed for trends.  90 days
<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 service has an education plan, but this has not been fully implemented.	i) Education around manual handling, health and safety, falls prevention and pressure injury prevention have not been conducted in the last two years. ii) The infection control nurse has not received infection control training in the last two years.	i - ii) Ensure all required training is provided.  90 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 Moderate	There is a menu that was approved by a dietitian in 2015. All food stored in the kitchen is stored appropriately but dried food stored in the basement is not stored in vermin proof containers and there was evidence of insects and birds having accessed the basement.	i) The current menu has not been reviewed since April 2015. ii) Dried food stored in the basement is not stored safely.	i) Ensure the menu is reviewed regularly. ii) Ensure dried foods are stored in appropriate areas or containers.  30 days
<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>	PA Moderate	Residents are weighed monthly or more frequently if weight is of concern. Person-centred care plans include early warning signs and symptoms as relevant, but care plans do not address all assessed needs. This remains an area for improvement.	Three of five residents did not have interventions to address all identified needs in the care plan - examples included diet, continence, and behaviour.	Ensure care plans document interventions for all identified needs.  60 days

<p>Criterion 1.3.8.2</p> <p>Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.</p>	<p>PA Low</p>	<p>Four of five care plans sampled had been reviewed six monthly as evidenced by a signature and the word "reviewed". The other file was not yet due for a six-monthly review. Evaluations did not all evidence progress to meeting goals.</p>	<p>Four of five care plans sampled did not document progress towards goals when they were reviewed.</p>	<p>Ensure progress towards goals are documented when care plans are reviewed.</p> <p>90 days</p>
<p>Criterion 1.4.2.1</p> <p>All buildings, plant, and equipment comply with legislation.</p>	<p>PA Low</p>	<p>Hot water temperature monitoring is completed for the communal hand basins/showers in each wing. Temperatures are not below 45 degrees Celsius in all the hand basin/shower areas.</p>	<p>Records from Jan- March 2018 reviewed identified water temperatures above 48 degrees. This is a consistent problem for the managers. Advised they get a plumber in at the time to adjust the tempering valve but do not document the corrective actions and effectiveness around this.</p>	<p>Ensure hot water temperatures are maintained at 45 degrees Celsius or below.</p> <p>90 days</p>

## Specific results for criterion where a continuous improvement has been recorded

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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.

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End of the report.