

Agape Care Limited - Milton Court Rest Home

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:	Agape Care Limited		
Premises audited:	Milton Court Rest Home		
Services audited:	Rest home care (excluding dementia care); Dementia care		
Dates of audit:	Start date: 12 January 2018	End date: 12 January 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: 31			

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

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

General overview of the audit

Milton Court Rest Home is privately owned and operated. The rest home provides rest home and dementia level of care for up to 36 residents. On the day of the audit there were 31 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, staff and the general practitioner.

The owner is the manager who is a registered nurse with a current practicing certificate. She is supported by a full-time registered nurse and long serving staff. The residents and relatives spoke positively about the care and supports provided at Milton Court Rest Home.

Two of the four previous audit findings have been addressed relating to the completion of adverse event forms and medication fridge temperature monitoring. Further improvements continue to be required around internal audit/satisfaction survey corrective actions and timeframes.

Two further improvements were identified through this audit around annual performance appraisals/reference checks and food safety.

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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Discussions with families identified that they are fully informed of changes in health status. The rights 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 medium or high risk and/or unattained and of low risk.
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Milton Court Rest Home has a documented quality and risk management system. Key components of the quality management system include management of complaints, implementation of an internal audit schedule, annual satisfaction surveys, incidents and accidents, review of infections, review of risk and monitoring of health and safety including hazards. Human resources policies are in place including a documented rationale for determining staffing levels and skill mixes. There is an orientation programme that provides new staff with relevant information for safe work practice. The education planner included mandatory educational requirements. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and there is sufficient staff on duty at all times.

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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Registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family input. Care plans viewed demonstrate service integration and are generally reviewed at least six monthly. Resident files include medical notes by the contracted general practitioners and visiting allied health professionals. Medication policies reflect legislative requirements and guidelines. Healthcare assistants are responsible for the administration of medicines and complete education and medication competencies. The activities coordinator and the activities assistant implement the activity programme to meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings, and celebrations. All meals are cooked on-site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated. There are snacks available at all times.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The building holds a current warrant of fitness.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The service maintains a restraint-free environment. There are policies and procedures to follow in the event that restraint or enablers are required. There were no residents using restraints or enablers. Staff have attended education on restraint and challenging behaviour within the last year.

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 type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	12	0	3	1	0	0
Criteria	0	35	0	3	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	A complaints policy and procedures are in place. Residents/family can lodge formal or informal complaints through verbal and written communication, resident meetings and complaint forms. Concerns/complaint forms are available at the front entrance. Information on the complaints forms includes the contact details for the Health and Disability Advocacy Service. A record of all complaints, both verbal and written is maintained by the manager (privacy officer) using a complaints' register. There has been one complaint made (in 2017) since the previous audit. The complaint reviewed was managed appropriately with acknowledgement, investigation and responses recorded. Interviews with residents and relatives are familiar with the complaints procedure and state any concerns or issues are addressed.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment	FA	Policies are in place relating to open disclosure. Management promote an open-door policy. Four relatives (two dementia and two rest home) interviewed were aware of the open-door policy and confirmed that the staff and management are approachable and available. Residents/relatives have the opportunity to feedback on service delivery through three monthly resident and relative meetings and the annual satisfaction survey. Five residents interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. Ten incident reports reviewed and associated resident files, evidenced recording of family notification. Relatives interviewed confirmed that they are notified of any changes in their family member's health status. Residents and family are informed prior to entry of the scope of services and any items they have to pay for that are

conducive to effective communication.		not covered by the agreement. The service has an interpreter policy to guide staff in accessing interpreter services. An introduction to the dementia unit booklet provides information for family, friends and visitors, visiting the facility.
<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>Milton Court Rest Home provides rest home level of care and dementia level of care for up to 36 residents. There are 16 rest home beds (Topaz rest home unit) and 20 dementia care beds (two 10 bed units, Amber and Turquoise). On the day of audit there were 13 rest home residents and 18 residents across the two dementia care units (eight residents in the Amber unit and 10 residents in the Turquoise unit). There were no residents on respite on the day of the audit. All residents were under the aged related residential care (ARCC).</p> <p>Milton Court is privately owned and operated by one director/joint owner of the company since 2009. The owner is the manager and is a registered nurse (RN) with a current practicing certificate. The manager is responsible for the daily operation of the business and is on-site Monday to Friday and shares the on-call with the other RN. The manager is supported by a full-time RN who has been at Milton Court since October 2014, the RN was absent on the day of the audit.</p> <p>There is an annual business plan in place for 2017, which identifies the philosophy of care, mission statement, business objectives and specific aims for the service. The 2016 business goals and objectives have been reviewed. The annual business plan for 2018 was being finalised at the time of the audit.</p> <p>The manager has maintained at least eight hours annually of professional development related to managing a rest home and dementia care facility. Professional development includes interRAI training and attending district health board manager meetings three times a year.</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 Moderate	<p>The service has a quality risk management plan in place that is reviewed annually. The service has in place a range of policies and procedures to support service delivery that are developed by an external consultant and reviewed regularly. Fortnightly manager, RN and supervisor meetings are in place. Staff meetings are held monthly and include quality improvement, infection control and health and safety. However, the meeting minutes do not evidence discussion around internal audit outcomes or improvements. This previous finding remains an area for improvement. Incidents and infections are collected and analysed. Trends and analysis for infection events are discussed and documented in meeting minutes. An annual internal audit programme is in place and audits have been completed as scheduled. Audit corrective action forms/quality improvement forms are raised where the results are less than expected, however, the documented corrective actions do not evidence they have been completed and/or signed off as completed. This previous shortfall remains an area for improvement</p> <p>The service completes an annual resident/relative satisfaction survey. The survey results have not been discussed at the monthly meeting. The maintenance person is responsible for building maintenance and is a health and safety officer who has completed level two of health and safety qualifications. Staff complete hazard forms for identified</p>

		hazards which are reviewed by the health and safety officer. There is a hazard register for each area of work that was last reviewed November 2017. Falls prevention strategies are in place that includes the reporting of falls and the identification of interventions on a case-by-case basis to minimise future falls.
<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>	FA	<p>There is an accidents and incidents reporting policy. Ten accident/incidents from December 2017 and January 2018 were reviewed. Either an RN or a healthcare assistant (HCA) commences incident/accident forms. All incident forms identified timely RN assessment of the resident and corrective actions to minimise resident risk. The accident/incident forms reviewed had been fully completed. This previous finding has now been addressed. The HCAs interviewed could discuss the incident reporting process. The manager collects incidents/accidents monthly to identify and analyse areas of improvement and identify if accidents/incidents could be prevented. Discussions with the manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been no requirements to complete any section 31 notifications since the last 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>	PA Low	<p>There are human resources policies to support recruitment practices. The register of RNs practising certificates and allied health professionals is current. Five staff files were reviewed (one RN, two HCAs, one cook and one activities coordinator). There was no documented evidence of an up-to-date annual performance appraisal completed in four of five staff files and no reference checks completed for five of five staff files reviewed. The orientation programme provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and believed new staff were adequately orientated to the service.</p> <p>Healthcare assistants are supported to commence Careerforce aged care qualifications following appointment and are supported by the manager, who is a Careerforce assessor. The manager and RN attend external education at the DHB and have completed interRAI training. A two-yearly training calendar includes mandatory education. Infection control and medication are scheduled and have been attended annually. Staff complete competencies relevant to their roles. Ten HCAs work in the dementia care unit and seven have completed the required dementia unit standards. Three HCAs who have been employed less than one year are in progress of completing.</p>
Standard 1.2.8:	FA	The human resources policy determines staffing levels and skill mixes for safe service delivery. There is a roster

<p>Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>that provides sufficient and appropriate coverage for the effective delivery of care and support. A full-time manager/RN (works from Monday to Friday) and RN (works from Saturday to Thursday) are on duty during the day and share the on-call responsibility. An experienced full time HCA (from Tuesday to Saturday) is the day supervisor who coordinates the team of HCAs on duty. There are sufficient staff numbers in the rest home and the dementia care unit that meets contractual requirements. Staff state they feel supported by the manager and RN who respond quickly to after-hour calls.</p> <p>There is a 16-bed rest home unit (Topaz), 10 bed dementia unit (Amber) and 10 bed dementia unit (Turquoise).</p> <p>In the Topaz rest home unit there are 13 residents, there is one HCA on the morning and afternoon shifts and one HCA on the night shift.</p> <p>In the Amber dementia unit there are eight residents, there is one HCA on the morning and afternoon shifts and one HCA on the night shift.</p> <p>In the Turquoise dementia unit there are 10 residents, there is one HCA on the morning and afternoon shifts and one HCA on the night shift.</p> <p>Interviews with HCAs, residents and family members identify that staffing is adequate to meet the needs of residents.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>There are policies and procedures in place for all aspects of medication management, including self-administration. There were no residents self-administering on the day of audit. There are no standing orders. There are no vaccines stored on-site. The facility uses a medico pack system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. HCAs administer medications in all units. Staff complete annual education, and medication competency is checked annually. The medication fridge temperature is checked weekly. This previous finding has now been addressed. Eye drops are dated once opened. Staff sign for the administration of medications. Ten medication charts were reviewed (four rest home and six dementia unit). Medications are reviewed three monthly by the GP. There was photo ID. Allergy status is recorded. 'As required' medications had indications for use charted.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's</p>	PA Low	<p>The service has a head cook who works Tuesday to Saturday and a cook that works Sunday to Tuesday. There is also a kitchen assistant. All have current food safety certificates. The head cook oversees the procurement of the food and management of the kitchen. There is a well-equipped kitchen and all meals are cooked on-site. Meals are served directly from the kitchen in the dementia unit and from electric warmers in the rest home. Special equipment such as lipped plates are available. On the day of audit, meals were observed to be hot and well presented. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits</p>

individual food, fluids and nutritional needs are met where this service is a component of service delivery.		<p>are implemented to monitor performance. Kitchen fridge and freezer temperatures were monitored and recorded weekly.</p> <p>Food temperatures are checked at lunchtime. The cooks prepare the evening meal and the kitchen assistant reheats and serves this. The food temperatures are not checked or recorded. The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. This is reviewed six monthly as part of the care plan review. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes were noted in a kitchen folder. The four-weekly menu cycle is approved by a dietitian. There are snacks available 24 hours a day in all units. Residents and families interviewed were satisfied with the food.</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>	FA	<p>When a resident's condition changes the RN initiates a GP consultation. Staff state that they notify family members about any changes in their relative's health status. All care plans sampled had interventions documented to meet the needs of the resident. Care plans have been updated as residents' needs changed. Resident falls are reported on accident forms and written in the progress notes.</p> <p>Care staff interviewed state there are adequate clinical supplies and equipment provided including continence and wound care supplies and these were sighted. Wound assessment, wound management and evaluation forms are in place for all wounds. Wound monitoring occurs as planned. There are currently two wounds. One wound has been seen by the GP and a referral has been made to the orthopaedic clinic. There are currently no pressure injuries.</p> <p>Monitoring forms are in use as applicable such as weight, vital signs and wounds. Behaviour charts are available for any residents that exhibit challenging behaviours and behaviour plans are put in place.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>There is one activities coordinator who works 32.5 hours a week and covers all areas. There is one activities assistant who works 15 hours a week and covers both areas. Both have had activities training. There is also a volunteer who comes in two days a week and works from 9.00 am to 3.00 pm. On the days of audit residents were observed walking in the garden, playing quoits and watching a movie. There is a weekly programme in large print on noticeboards. Residents have the choice of a variety of activities, in which to participate and every effort is made to ensure activities are meaningful and tailored to residents' needs. These include exercises, games, music, quizzes and walks outside. The rest home residents who have electric scooters like to 'motor' down to the reserve by the sea. There are also nearby shops and cafes they can visit.</p> <p>Those residents who prefer to stay in their room or who need individual attention have one-on-one visits to check if there is anything they need and to have a chat. There are no church services held in the facility, but families may take residents out to church. Provision can be made for Catholics to receive communion. Each area has a weekly van outing. There is a musical entertainer who visits fortnightly and there is pet therapy weekly. Special events like</p>

		birthdays, Easter, Mothers' Day, Anzac Day and Melbourne Cup are celebrated. Residents have an activity assessment completed over the first few weeks following admission that describes the residents past hobbies and present interests, career and family. Resident files reviewed identified that the individual activity plan is based on this assessment. Activity plans are evaluated at least six monthly at the same time as the review of the long-term care plan. Resident meetings are held three monthly.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	The two rest home care plans reviewed had been evaluated by the RN six monthly or when changes to care occurs. Two out of three dementia unit care plans reviewed had not been evaluated by the RN six monthly (link 1.3.3.3). Short-term care plans for short-term needs are evaluated and signed off as resolved or added to the long-term care plan as an ongoing problem. Activities plans are in place for each of the residents and these are also evaluated six monthly. The multidisciplinary review involves the RN, GP and resident/family if they wish to attend. There is at least a three-monthly review by the GP. The family members interviewed confirmed that they are informed of any 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	The building holds a current warrant of fitness which expires on 1 June 2018.
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	FA	Policies and procedures document infection prevention and control surveillance methods. Systems are in place that are appropriate to the size and complexity of the facility. The surveillance data is collected monthly. Analysis is done but could be more extensive using the form the facility already has. Infection control internal audits have been completed. Infection rates have been low except for one month when there was an increased rate of lower respiratory infections. Trends are identified, and quality initiatives are discussed at staff meetings. There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place appropriate to the complexity of service provided. All infections are included in infection control surveillance data.

control programme.		
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There are policies and procedures on restraint minimisation and safe practice. Policy includes guidelines and definitions for use of enablers and restraint. The manager/RN is the restraint coordinator. On the day of the audit there were no residents on restraints or enablers. Restraint education and challenging behaviours is included in the annual training programme and occurred in November 2017 and August 2017 respectively.</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)
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Moderate	Accident/incidents and infections are collected and analysed. Trends and analysis for infection events are discussed and documented in meeting minutes. Internal audits and surveys are completed. Meeting minutes do not evidence discussion around internal audit outcomes and resident/relative satisfaction survey results. Corrective action forms/quality improvement forms are completed for any areas of improvement resulting from internal audits, but these have not been documented as completed/signed off. This remains an area for improvement from previous audit.	(i) Meetings minutes do not evidence discussion around internal audit outcomes and relative/resident satisfaction survey results. (ii) Internal audits had been completed with corrective action/quality improvement forms raised for areas of improvement. However, corrective actions had not been documented as followed-up and signed off as completed.	(i) Ensure discussions at meetings around internal audit outcomes and resident/relative satisfaction survey results are documented in meeting minutes. (ii) Ensure corrective actions are followed-up and signed off as completed. 60 days

<p>Criterion 1.2.7.2</p> <p>Professional qualifications are validated, including evidence of registration and scope of practice for service providers.</p>	PA Low	<p>There are human resources policies to support recruitment practices. Five staff files were reviewed (one RN, two HCAs, one cook and one activities coordinator). Not all files had an up-to-date annual performance appraisal completed and there were no reference checks completed in the staff files reviewed.</p>	<p>There was no documented evidence of an up-to-date annual performance appraisal completed in four of five staff files and no reference checks completed for five of five staff files reviewed.</p>	<p>Ensure that all staff performance appraisals are completed annually. Ensure that reference checks completed for new staff are kept in the staff file.</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>	PA Low	<p>The head cook procures all food and oversees that it is stored safely. All food is prepared in a clean and well managed kitchen and meets guidelines. Food temperatures are taken at lunchtime, but these are not recorded. The cooks prepare the evening meal and the kitchenhand reheats and serves these. Food temperatures are not taken or recorded. The meals are transported to the rest home in electric warmers on a trolley. All disposal of food meets guidelines.</p>	<p>i) No food temperatures are documented at lunchtime.</p> <p>ii) The cook prepares the evening meal and the kitchen assistant reheats these. There is no documented evidence of any food temperatures being taken.</p>	<p>Ensure food temperatures are taken and documented.</p> <p>30 days</p>
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and</p>	PA Low	<p>Assessments and planning is completed within the required timeframes. Two out of two rest home care plans reviewed had evaluations completed within the six-month timeframe. Two out of three dementia unit care plans did not have evaluations completed within the six-month timeframe. Short-term care plans are in use and these are discontinued when the problem has been resolved. Those problems that are ongoing are transferred to the long-term care plan. The activities coordinator evaluates the activities plan six monthly or as</p>	<p>Two long-term care plans (dementia care) have not been evaluated six monthly.</p>	<p>Ensure long-term care plans are evaluated six monthly.</p> <p>60 days</p>

exit) is provided within time frames that safely meet the needs of the consumer.		required. These are generally done in liaison with the RN when she is completing the interRAI update and care plan evaluation.		
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Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.