Devonport Palms Retirement Limited - Devonport Palms

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:	Devonport Palms Retirement Limited
Premises audited:	Devonport Palms
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 27 February 2020 End date: 27 February 2020

Proposed changes to current services (if any): The service has applied to the Ministry of Health to increase the total number of beds from 30 to 34. Four suites were verified to be able to support two residents in each bedroom.

Total beds occupied across all premises included in the audit on the first day of the audit: 28

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

Devonport Palms is privately owned and operated and provides care for up to 30 residents requiring rest home level care. On the day of the audit there were 28 residents. The service has requested verification of four rooms (referred to as suites) to be able to provide accommodation for two residents in each. The audit verified the suitability of the four suites to be utilised for couples.

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 a review of relevant policies and procedures; a review of resident and staff files; observations; and interviews with residents, family, management, and staff.

The service is managed by a facility manager who has been in the role for seven months. They are supported by the clinical manager who is also newly appointed. The two positions are actively supported by the Managing Director who has 15 years aged-care management experience as a managing facility owner. He is available on a daily basis for peer support and advice and was on annual leave on the day of the audit. Additionally, as part of the Cavell Group there is wider support from each facility and clinical manager.

The service has addressed one of the two previous audit shortfalls around medication documentation. A further improvement continues to be required around food services.

This audit identified that improvements are required around timeframes; documentation of interventions; medication management and call bells in the suites verified as suitable for couples.

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.

Residents are provided with information they need on entry to the service and this is regularly updated. Interviews with residents and family confirmed they are provided with adequate information and that communication is open. Family members stated that they are informed of any change of care or incident related to their family member when this occurs.

Residents are informed of the complaints process and there are policies and procedures in place to investigate complaints with these investigated in a timely manner.

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.

The Cavell group quality management system describes Devonport Palms quality improvement processes. Progress with the quality management programme is monitored through the three-monthly quality/health and safety/infection control meetings. Data is collected on complaints, accidents, incidents, infection control and restraint use. There is a current business plan in place.

Resident/relative meetings are held three monthly. There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an annual training schedule for in-service education with this implemented. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care for rest home residents.

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.

Assessments, care plans and reviews are completed by a registered nurse. Each resident has access to an individual and group activities programme. The group programme is varied. Medication is managed in line with legislation and guidelines. General practitioners review residents at least three monthly or more frequently if needed. Meals are prepared on site. The menu is varied and appropriate. Individual and special dietary needs are catered for. Alternative options are provided. Residents interviewed were complimentary about the food service.

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.		Some standards applicable to this service partially attained and of low risk.

The building has a current warrant of fitness. Preventative and reactive maintenance occurs.

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.

Devonport Palms has restraint minimisation and safe practice policies and procedures in place. There is one resident requiring the use of a bedrail defined as restraint and two residents using bedrails identified as an enabler. Staff receive training in restraint minimisation.

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.

A surveillance programme is documented and undertaken, and this is appropriate to the size and complexity of the service. Results of surveillance are reported to relevant personnel in a timely manner. There have been no outbreaks since the previous audit.

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	11	0	1	4	0	0
Criteria	0	36	0	1	4	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	The complaints policy and procedures have been implemented and residents and their family/whānau are provided with information on admission. The residents and family members interviewed were aware of the complaints process and to whom they should direct complaints. Complaint forms are visible at the entrance of the facility. A complaints register is maintained. There have been no complaints made since the last audit in August 2018. All six residents and one of the two family members interviewed praised the service and all stated that they had no complaints. The second family member had not specifically raised complaints with the managers. There have not been any complaints sent to the service through the Health & Disability Commissioner (HDC) or from any other external agency since the last audit.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and	FA	There is a policy to guide staff on the process around open disclosure. Residents and family are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement. Six rest home residents and two relatives interviewed confirmed that management and staff are approachable and available. Fifteen incident forms reviewed, identified family were notified following a resident incident. Relatives interviewed confirmed they are notified of any incidents/accidents. Families are invited to attend the three-monthly resident/family meeting. The service has policies and procedures available for access to interpreter services for

provide an environment conducive to effective communication.		residents (and their family). If residents or family/whānau have difficulty with written or spoken English, then interpreter services are made available. One family member interviewed stated that it was difficult to get someone to answer phones at the service after hours. This has been verbally fed back to the managers.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Devonport Palms is owned and operated by a member/director of the Cavell group. The Cavell group is comprised of a group of six independent aged care providers who share policies and provide collegial support while maintaining their independent businesses. Devonport Palms provides care for up to 30 residents requiring rest home level care. On the day of the audit, there were 28 residents in total. All residents were under the age-related residential care (ARRC) agreement. Twenty-seven of the twenty-eight residents were assessed as requiring rest home level of care (two were receiving respite care) and one required hospital level of care. The facility manager stated that to their knowledge there was no documentation confirming that the district health board were aware of a resident requiring hospital level of care and they had not requested dispensation from the Ministry. The portfolio manager was phoned and confirmed that they were not aware of a resident requiring hospital level care in the service. This was addressed on the day of audit and dispensation received from HealthCERT. The service is managed by a facility manager who was appointed to the role seven months ago. The facility manager has had six years' experience working in residential disability services in management roles. She has a certificate in business studies and is currently completing a leadership course offered through the district health board. The clinical manager was appointed six months ago and has six years' experience in surgical nursing. The facility and clinical managers are both registered nurses and have a current practicing certificate. They meet with the owner who has been with the service for over 15 years on a daily basis. The Ministry of Health was notified by a section 31 of the change in managers. Devonport Palms has a current 2018/2019 business plan that includes goals and objectives. The goals and objectives for 2017/2018 have been reviewed and were documented as being achieved. The business plan incorporates the risk management plan and goals for each area of service delivery and organisational management. The facility manager/owner is responsible for the operational and financial aspect of the business. The facility manager has attended at least eight hours of professional development that relates to managing a rest home including NZ Aged Care Association and quality management training courses.
Standard 1.2.3: Quality And Risk Management	FA	The Cavell group quality management system describes Devonport Palms quality improvement processes. Progress with the quality management programme has been monitored through the three-monthly combined

Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.		quality/health and safety/infection control meeting. The meetings cover matters arising from the monthly staff and three-monthly resident meetings; health and safety; complaints; accidents/incidents; and infection control; issues arising from internal audits; and survey results and outcomes. In the past, meetings have not been held as frequently as they now are, and meeting minutes have been maintained. Staff are expected to read the minutes. Minutes for all meetings have included actions to achieve compliance where relevant. Data is collected on complaints, accidents, incidents, infection control and restraint use and tabled at the relevant meetings. Staff interviewed, confirmed they are well informed and receive quality management programme information including accident/incident and infection control data. The internal audit schedule for 2019 has been completed and the 2020 schedule is being implemented in a timely manner. The service has implemented a health and safety management system. Risk management, hazard control and emergency policies and procedures are being implemented and are monitored at the combined meeting. Hazard identification forms and an up-to date hazard register (last reviewed 19 March 2018) are in place. The service has policies/procedures to support service delivery. An annual resident and relative satisfaction survey (June 2018) has been conducted with respondents advising that they are overall very satisfied with the level of care and service they receive. Falls prevention strategies are in place that includes the identification of interventions on a case-by-case basis to minimise future falls.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	PA Moderate	There is an incident reporting policy that includes definitions and outlines responsibilities. Fifteen accident/incident forms for February 2020 were reviewed. All forms indicated that family had been informed of the incident and the form had been signed off by the facility manager. Neurological observations had not been completed as per policy in 12 of the 14 incident forms. The facility manager stated that to their knowledge there was no documentation confirming that the district health board were aware of a resident requiring hospital level of care and they had not requested dispensation from the Ministry. The portfolio manager were notified during the audit of the resident requiring hospital level care in the service. HealthCERT were also notified, and since the draft report the service has received dispensation from HealthCERT. The documentation provided by the need's assessor confirmed that the resident had been assessed on 21 March 2019 from rest home to hospital level of care. Managers stated that the family has requested that the resident remain at the service and staff interviewed confirmed they can safely manage the resident. Discussions with the facility manager confirmed an awareness of the requirement to notify relevant authorities in relation to essential notifications including section 31 notifications and examples were provided.

Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	There are human resources policies to support recruitment practices. Five staff files (one team leader/caregiver, two caregivers, one cook and one clinical manager) were reviewed. The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and suitability for the role. Performance appraisals were current. A current practising certificate was sighted for the clinical manager. The service has an orientation programme in place to provide new staff with relevant information for safe work practice. All staff have completed orientation as sighted through the checklists completed. Staff interviewed were able to describe the orientation process and stated that they believed new staff are adequately orientated to the service. The clinical manager and caregivers' complete competencies relevant to their role such as medications. There is an education planner in place that covers compulsory education requirements over a two-year period. The clinical manager has completed interRAI training and has attended education sessions at the district health board (DHB).
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	Devonport Palms has a roster in place, which provides sufficient staffing cover for the provision of care and service to residents. Staffing rosters were sighted and there is an adequate number of staff on duty to meet the residents' needs on different shifts. The facility and clinical managers are on site from 7.30 am until 4.30 pm Monday to Friday and they alternate on-call 24/7. There is a full-time clinical manager on site five days a week Monday to Friday and is on-call 24/7 for any clinical concerns. The local general practitioner (GP) also provides afterhours care if required and the caregivers have access to the local ambulance service. The residents are supported by two caregivers on duty on the morning shift, one caregiver on duty on the afternoon shift and one caregiver on the night shift. Additionally, there is one hospitality/caregiver on duty from 6.30 am to 10.30 am and from 4.00 pm to 8.00 pm to help with showering and meals. There are two levels (upstairs and downstairs). Staff on the morning and afternoon shift separate to take upstairs or downstairs but work as a team if required. At night, the caregiver on duty manages both floors with most residents sleeping through the night. One caregiver on afternoons who was interviewed stated that they are on duty by themselves from 8 pm to 11 pm and there are usually only one or two residents up at that time. Roster shortages or sickness are covered by casual or off duty staff with rosters for the last two months confirming that this occurred. The caregivers and residents interviewed reported that there is sufficient staff cover. There are also two caregivers that live next door to the facility who are available for any caregiver replacement roles or assistance if required. Staff interviewed could give examples of when the caregivers had been rung afterhours to support a specific resident and they had responded immediately.
Standard 1.3.12: Medicine Management	FA	Ten medication charts were reviewed (one hospital and nine rest home resident files including one respite resident with medications). An electronic medication system is in place to manage safe and appropriate medicine

Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.		management. Photo identification was present on medication files. Medication files reviewed identified that they have been reconciled, medications were fully charted by GPs, short term medications include an end date, and signing charts were fully completed. These are improvements on the previous audit. Medication prescribed is signed as administered on the electronic system. There is evidence of three-monthly reviews by the GP. All senior staff who administer medications have completed a practical and written medication competency annually. Medications are checked on delivery against the medication chart by the RN. Standing orders are not used. The facility uses a blister pack medication management system for the packaging of all tablets. One resident self-administers medication and has a current competency assessment, which has been reviewed three monthly by the GP. Medications were stored safely in a locked cupboard in the nurses' station. The medication fridge is monitored daily as sighted in records reviewed. There was a system in place for monitoring the medication room temperatures. Eye drops and other short-term medications are dated when opened.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	PA Moderate	There is a functional kitchen adjacent to the dining room, and all food is cooked on site. There is a food services manual in place to guide staff. The kitchen can meet the needs of residents who require special diets and the cook works closely with the RN. The two cooks have completed food safety training. The cook follows a rotating menu which has been reviewed by a dietitian. Supplements are available for residents who experience unintentional weight loss. There is special equipment available for residents if required. A food control plan is in place expiring on 25 July 2020. The temperatures of refrigerators and freezers are recorded and were within required ranges. Cooked foods are monitored and recorded as specified in the food control plan. All food is stored appropriately and is dated to ensure good stock rotation. Incoming perishable food temperatures are not being recorded as stated as being required in the food control plan. Advised that 90% of perishable food is in fact frozen. There was a misunderstanding in respect to temperatures being recording for remaining food. This has now been addressed. Cleaning schedules are in place and are adhered to. Residents interviewed were very happy with food service provided.
Standard 1.3.6: Service Delivery/Interventions Consumers receive	PA Moderate	When a resident's condition alters, the registered nurse initiates a review and if required, GP or nurse specialist consultation. There is evidence that relatives 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 relatives and notifications are documented in the resident files reviewed.

adequate and appropriate services in order to meet their assessed needs and desired outcomes.		Monitoring occurs for blood pressure, weight, vital signs, bowels, blood glucose and pain. One resident had not been weighed as the resident was unable to stand and the facility only had scales suitable for residents to stand on. Neurological monitoring forms had not been completed for unwitnessed falls or a potential head injury (link 1.2.4.3). In two of five files reviewed the intervention documented reflected residents assessed needs. In three of five files reviewed the intervention did not reflect all of the resident's assessed needs. Adequate dressing supplies were sighted. There were three residents with wounds on the day of the audit. Wound assessments, plans and evaluations were in place. There is access to a wound nurse specialist from the DHB if required. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified.
Standard 1.3.7: Planned Activities 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.	FA	The activities team includes a team of two staff. One activities team member works 28 hours per week and the other activities team member works on Mondays. An initial activities assessment and six-monthly review of residents' activity needs is undertaken by the activities team. Activity assessments, attendance forms and evaluations were sighted. Each resident is free to choose whether they wish to participate in the group activities programme or their individual plan. Popular activities include bingo, exercises, newspapers, quizzes, sunshine club and gentlemen's club. One-on-one activities are provided for residents who do not want to participate in group activities. Activities include chats and updates with residents. The children from the local childcare visit once a month, and local church groups also visit. Participation is recorded. Group activities include visits to the community; this has included trips to the Classic Flyers museum and Golden Age Club. The facility has a vehicle that up to three residents can travel in, and once a month a van is hired for outings. Resident meetings have been held and the activities team receive feedback on activities within the group on a one-to-one basis. Residents and relatives interviewed commented positively on the activity programme.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and	FA	Initial care plans reviewed were evaluated by the RN within three weeks of admission. Files sampled demonstrated that long-term care plans were not always evaluated at least six-monthly (link 1.3.3.3). Short-term care plans sighted were evaluated and resolved or added to the long-term care plan if the problem was ongoing, as sighted in resident files sampled apart from in one file reviewed (link 1.3.6.1). The GP reviews the residents at least three monthly or earlier if required.

timely manner.		
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	PA Low	The building has a current warrant of fitness expiring on 21 January 2021. All equipment has been tested and calibrated. There is a large central communal lounge adjacent to the large dining room. All resident rooms are personalised to personal taste. There are adequate shared toilet and shower rooms available for residents. All areas are accessible to residents requiring mobility aids. The external garden areas are accessible, well maintained and provide seating and shade. Devonport Palms intends re-configuring services provided, increasing the number of beds from 30 to 34. The four additional beds are to be in the bedrooms located in apartments one, two, three and six (verification that any of the four rooms could include a couple). These apartments have bedrooms with a full ensuite off the bedroom and a separate lounge with kitchenette. The bedrooms and lounges also have small balconies. These apartments are comfortable and spacious enough to house a couple if this should be desired. There is no change to the physical configuration of the home or apartments. There was no additional call bell in place on the day of the audit. An additional call bell will need to be added to each room prior to the rooms being used for a couple.
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.	FA	Policies and procedures document infection prevention and control surveillance methods. Definitions of infections are in place and appropriate to the complexity of service provided. The surveillance data is collected throughout the month with some analysis monthly to identify areas for improvement or corrective action requirements (link to 1.2.3.6). Data is reported to and benchmarked monthly with other facilities in the Cavell group infection committee. Infection rates have remained low. Any trends identified, including quality initiatives are discussed at both the Cavell group management meeting and site staff meetings (link to 1.2.3.6). Infection control internal audits have been completed (link to 1.2.3.8). There have been no outbreaks since the previous audit.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Devonport Palms has restraint minimisation and safe practice policies and procedures in place. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. There is one resident using a bedrail and they are not able to voluntarily give consent for this noting that family have given consent. This is documented as a restraint. Two residents are also able to request bedrails, and these are documented as enablers. Staff receive training in restraint minimisation, which was last completed in 2019.

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 1.2.4.3 The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities	PA Moderate	Of the fifteen incident forms reviewed, there were 14 for residents who had an unwitnessed fall. All had been signed off by the facility manager. Two of the 14 residents were able to state that they had not hit their head, were able to describe the incident and this was recorded on the form. Neurological observations had not been completed as per policy in 12 of the 14 incident forms.	Neurological observations have not been completed for 12 residents who have had an unwitnessed fall as per documentation in the incident form.	Ensure that neurological observations are completed as per policy when a resident has an unwitnessed fall or has a fall with a head injury.

to improve service delivery, and to identify and manage risk.				90 days
Criterion 1.3.13.5 All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.	PA Moderate	All food is stored appropriately and is dated to ensure good stock rotation. Incoming perishable food temperatures are not being recorded as stated in the food control plan.	There was no evidence that incoming perishable food temperatures are being recorded as stated in the food control plan which states in 3.8.2 of the facility's food control plan, "The temperature of perishable food must be measured on reception once a month, or when there is a change of supplier, or when there is a cause to suspect that the food is not within the correct temperature range." The cook advised that no temperatures are recorded for incoming perishable food. The improvement had been raised at the last audit and the timeframe to complete this improvement has been raised from a low to moderate risk rating. Advised that 90% of perishable food is in fact frozen. There was a misunderstanding in respect to temperatures being recording for remaining food. This has now been addressed.	Ensure that incoming perishable food temperature is recorded as specified in the food control plan. 90 days
Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the	PA Moderate	The registered nurse is responsible for the admission assessment and development of care plans. Files reviewed identified initial assessments had been completed within the required timeframe. Two initial interRAI assessments and 16 interRAI assessments for long-term files (this included one hospital resident and 15 long-term residents) had not been completed within the required timeframe. All files had a long-term person-centred care plan in place however a long-term care plan had not been reviewed six monthly.	(i) InterRAI assessments had not been completed and reviewed within the required timeframe for two initial interRAI assessments (in files reviewed) and 16 long-term residents files (this included one long-term hospital resident and 15 rest home residents). (ii) The hospital resident's long-term care plan had not been reviewed six monthly.	(i) Ensure all initial interRAI assessments and all six monthly interRAI assessments are completed within the required timeframes. (ii) Ensure all long-term care plan

needs of the consumer.				evaluations are completed within the required timeframes. 90 days
Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Moderate	Five resident files were reviewed, one hospital and four rest home level. In two of five files reviewed the interventions reflected residents assessed needs. In three of five files reviewed the intervention did not reflect all of the resident's assessed needs.	(i) One resident had a diagnosis of behavioural concerns and mental health issues and there was no behaviour management plan in place. (ii) The hospital resident had a bed rail restraint in place. There was a chart in place that staff completed when they re-positioned the resident. The nursing care plan and the repositioning chart did not include any instructions on frequency of re-positioning or restraint management. The chart had not been completed on a regular basis. (iii) The hospital resident had not been weighed in a timely manner as the facility did not have suitable scales. The residents care plan was not updated to reflect changes in health care needs; and (iv) The rest home level resident tracer was unwell with a chest infection. There was no short-term care plan in place for the chest infection and the resident's care plan did not reflect the resident's chest infection or care needs related to the chest infection.	(i) Ensure that where there are behavioural management concerns there is a behaviour management plan in place. (ii) Ensure nursing care plans include all restraint management and re-positioning requirements and charts demonstrate the monitoring requirements. (iii) Ensure that resident's weight is

				monitored as required. Ensure care plans are updated are to reflect a change in health care needs; and (iv) Ensure short-term care plans with links to the long-term care plan are in place to address care needs including resident's with chest infections. 90 days
Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.	PA Low	Devonport Palms intends re-configuring services provided, increasing the number of beds from 30 to 34. The four additional beds are to be in the bedrooms located in apartments one, two, three and six. These apartments are comfortable and spacious enough to house a couple if this should be desired. There is no change to the physical configuration of the home or apartments. There was no additional call bell in place on the day of the audit. An additional call bell will need	There was no additional call bell in place in the bedroom within apartments one, two, three and six on the day of the audit.	An additional call bell will need to be added to each room prior to the rooms being used for a couple. Prior to

		to be added to each room prior to the rooms being used for a couple.		occupancy days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.