

Bizcomm New Zealand Limited

Introduction

This report records the results of a Surveillance Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity:	Bizcomm New Zealand Limited	
Premises audited:	Manor Park Private Hospital	
Services audited:	Hospital services - Medical services; Hospital services - Mental health services; Hospital services - Geriatric services (excl. psychogeriatric)	
Dates of audit:	Start date: 26 January 2015	End date: 26 January 2015
Proposed changes to current services (if any):	None	
Total beds occupied across all premises included in the audit on the first day of the audit:	53	

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

Manor Park Private Hospital is certified to provide hospital level care for up to 54 psychogeriatric and mental health residents. On the day of audit there were 53 residents. The manager is a registered nurse and is supported by a care-coordinator and quality improvement co-coordinator. This unannounced surveillance audit was conducted against a subset of the Health and Disability standards and the contract with the District Health Board. The audit process included a review of policies and procedures; the review of resident's and staff files, observations and interviews with residents, relatives, staff and management.

All six shortfalls identified at the previous audit have been addressed. These related to, safe storage of chemicals, advance directives, pain assessments, aspects of medication documentation, staff training and servicing of equipment.

This audit also identified improvements required around evaluation of short term care plans, safe food handling, medication documentation and care interventions.

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 a documented complaints procedure which complies with the Health and Disability Code. Complaints information is available for residents and relatives. Implementation of an organisational database ensures all complaints are monitored and closed out as required. The service practices open disclosure. Staff and families reported good communication and being kept informed.

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.		Standards applicable to this service fully attained.
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There are documented values and a mission statement that focuses on providing the highest standard of personal and individual care to each resident and to maintain the dignity and wellbeing of each resident. The manager has been in position for three months and is a registered nurse. She is supported by senior leaders including a registered nurse with qualifications in mental health.

Manor Park private Hospital has a quality and risk management system in place that is implemented and monitored and this generates improvements in practice and service delivery. Key components of the quality management system link to the facility meetings including quality management, health and safety and staff meetings. Corrective actions are identified and implemented.

Human resource policies are in place with recruitment as per policy. There is an orientation and training programme that provides staff with relevant information for safe work practice and an in-service education programme that exceeds eight hours annually and covers relevant aspects of care.

Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Registered nurses are responsible for each stage of service provision. The provider has systems to assess, plan and evaluate care needs of the residents. Resident files include notes by the GP and allied health professionals

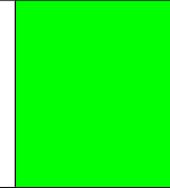
Medicines are managed and policies reflect legislative requirements. Registered nurses and enrolled nurses are responsible for administration of medicines and complete annual medication competencies and education. The general practitioner/psychogeriatrician review the medication charts three monthly and there is a current standing order that meets the requirements. These are improvements since the previous audit.

The activities programme is facilitated by a diversional therapist, an activities coordinator and volunteers. The activities programme provides activities that meet the consumer groups in each unit. Residents have an individualised 24 hour activity plan. All food is cooked on site. All residents' nutritional needs are identified and documented. Choices are available and are provided. Meals are well presented and the menu plans have been reviewed by a dietitian.

Care plans document early warning signs and interventions in response to these and risks are well documented for mental health residents.

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.

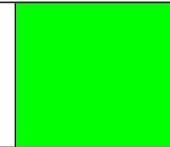


Standards applicable to this service fully attained.

Chemicals are stored safely and not left unsupervised. The building holds a current warrant of fitness and hoists and scales have been checked and serviced.

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.

The organisation has policies and procedures around 'not using' restraint. All staff receive training on de-escalation and management of challenging behaviours and there is no evidence to suggest that restraint is used. There is one enabler and no restraint used in the service. The family have consented to the use of the enabler. Challenging behaviours are managed according to plans documented as required.

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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Surveillance data is collated monthly and reported to the quality and health and safety meetings. Review of the data indicates that there is a low infection rate. Systems in place were appropriate to the size and complexity of the facility.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	17	0	3	1	0	0
Criteria	0	41	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
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Advance directives sighted in resident files (two mental health and three psychogeriatric) documented evidence of GP discussion with the family/enduring power of attorney. This is an improvement since the previous audit.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service has complaints management policies and procedures in place and residents and their family/whanau are provided with information on the complaints process on admission through the information pack. Family members interviewed stated that they knew how to make a complaint if they needed to</p> <p>Staff were aware of the complaints process and to whom they should direct complaints. The complaint process is in a format that is readily understood and accessible to residents/family/whanau. There is a complaints register in place.</p> <p>Six complaints received in 2014 were reviewed and all were dealt with promptly with evidence that there was satisfactory resolution as stated in emails from the complainant. The review indicated that the complaints are actively managed in accordance with Manor Park Private Hospital policy.</p>

		The Ministry of Health received an anonymous complaint in 2014. The outcomes of the investigation of this were followed through in all relevant meetings.
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Open communication commences upon residents being admitted.</p> <p>The manager has an open door policy. Six family members (four psychogeriatric and two mental health) stated that they are kept informed at all times.</p> <p>The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.</p> <p>The manager is aware of how interpreters can be accessed if needed.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Manor Park Private Hospital is privately owned. The service provides care for up to 54 residents. On the day of audit there were 46 psychogeriatric residents and seven mental health residents. The owner of the service provides a support for the manager with meetings on site each one to two days. He also takes responsibility for the financial management and has documented the strategic/business plan. The 2015 strategic plan contains goals and objectives for the service and the mission. The 2014 strategic goals have been reviewed. The manager is a registered nurse with a current APC. She has been at the service for three months and has many years' experience in mental health and aged care.</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>	FA	<p>The quality system continues to be implemented at Manor Park Hospital. Interviews with caregivers confirmed that quality data is discussed at monthly staff meetings. There is also a monthly quality improvement meeting where all quality data and indicators are discussed. Minutes of these meetings are made available to all staff.</p> <p>There are policies and procedures appropriate for service delivery. Policy manuals are reviewed two yearly.</p> <p>The service collects internal monitoring data (internal audits) with the audit schedule being implemented by the quality co-ordinator. Quality improvement data such as incidents /accidents, hazards, internal audit, infections are collected and analysed/evaluated at the quality meeting. Corrective action plans have been developed for incident reports.</p>

		<p>There is implemented risk management, and health and safety policies and procedures in place including accident and hazard management.</p> <p>The service has an implemented internal audit schedule and when issues are identified, there is evidence in the monthly quality meeting minutes that these are followed up and issues resolved.</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>	FA	<p>Incident data is collected monthly and compared with clinical indicators. Outcomes are discussed at quality improvement, and health and safety meetings. Minutes are available for staff to read.</p> <p>Twelve incident forms sampled evidence detailed investigations and corrective action plans following incidents. Incident forms sampled where there has been a head injury have been followed up with neuro -observations.</p> <p>Monthly data is taken to the quality improvement meeting. The seven caregivers and the registered nurse interviewed could describe the process for management and reporting of incidents and accidents.</p> <p>Discussions with the manager and clinical co-ordinator service confirms an awareness of the requirement to notify relevant authorities (DHB) or (MOH) in relation to essential notifications. The manager states that there has been a coroner's investigation with no further action required. There was also an outbreak of a virus notified to the department of health in April 2014 which was followed up by them.</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>	FA	<p>Five staff files were reviewed and included current performance appraisals. Current practicing certificates were sighted.</p> <p>The service has an internal training programme that covers all areas of care and support and exceeds eight hours in 2014. Staff have specific mental health training around clozapine and safe nursing practice, managing challenging behaviours, code of rights/advocacy, behaviour monitoring and Huntington's awareness.</p> <p>Staff have a comprehensive orientation when they join the service and this includes buddying with other staff. New staff are supported to learn how to manage challenging behaviour in supportive and appropriate ways.</p> <p>This enables registered nurses to complete care plans using a mental health perspective. Managers and staff talked of the value of the training programme.</p>

		<p>Family member's state that staff are knowledgeable and very skilled at managing what they state are very difficult behaviours.</p> <p>The caregivers in the service have completed CareerForce core training. The 15 registered nurses and two enrolled nurses have completed the required dementia standards. Newly employed staff are yet to commence.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>Staffing rosters were sighted and there is adequate staff on duty in each area to match the needs of the residents and different shifts. There are extra staff allocated when required. There is a registered nurse on duty 24 hours per day. The facility manager and clinical manager are registered nurses who work full time.</p> <p>Staff turnover is moderate. The seven caregivers and registered nurse interviewed stated that there is adequate staffing to manage their workload on any shift.</p> <p>In the AM shift the clinical co-ordinator is on and the nurse manager and they help out as required. In the PM the short shifts are three pm – eight thirty to support care during sundowning.</p> <p>Heritage: AM: three caregivers (two full shifts), one registered nurse; PM: two caregivers (one full shift, one short shift), one registered nurse; night: one caregiver.</p> <p>Harris: AM: four caregivers (full shifts), one registered nurse; PM: four caregivers (three full shifts, one short shift), one registered nurse; night: one caregiver, one registered nurse who is stationed in Harris but supports all areas.</p> <p>Endeavour: AM: two caregivers, PM: two caregivers (one full shift, one short shift), night: one caregiver/enrolled nurse.</p> <p>Any leave is covered by internal staff not bureau and this helps to settle residents as there are known staff.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>Mental Health: All relevant information was documented and communicated to the receiving health provider or service when a resident moves to another service. A transfer form accompanied residents to receiving facilities. Follow up occurs to check that the resident is settled, or in the case of death, communication with the family is made. There have been no discharges from the mental health unit to the community since the previous audit. Residents leaving the mental health unit have been</p>

		transferred to another aged care facility.
<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>	PA Low	<p>All medication is managed appropriately in line with required guidelines and legislation. RN's and EN's only administer medications and have completed annual competencies and have attended education. Standing orders are current and meet the MOH medication guidelines 2011 and the GP orders for bowel management have been obsoleted. These are improvements since the previous audit. There are no self-medicating residents. Families are invited to the three monthly medication review with the GP/psychogeriatrician. A medication monitoring form was put place for residents commenced on any new or changes to psychotropic medications. Any adverse reactions, increased risk factors or other concerns are reported back to the GP. Blood levels are monitored for specific medications.</p> <p>Ten medication charts (six psychogeriatric and four mental health) sampled identified the GP had reviewed the medication charts at least three monthly. This is an improvement since the previous audit. A shortfall is identified around GP discontinuation of medication documentation.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	PA Low	<p>There are six staff who work in the kitchen and not all have completed food safety training. There is a dietitian approved menu. The cook receives a nutritional assessment when resident needs change that includes dietary needs, special diets and resident preferences. These are catered to. Special lip plates and utensils are available for residents to help promote independence with meals. Meals are delivered to the units, plated and in hot boxes. Snacks are available 24 hours per day.</p> <p>Fridge and freezer temperatures were regularly recorded until late December 2014. There is an improvement required around food safety.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>The previous audit identified that mental health files did not have a pain assessment or pain management when the resident had pain. Both mental health files reviewed for this audit had regular pain assessments with one of the two residents having pain levels monitored daily following a reduction in analgesia. The previous shortfall has been addressed.</p>

<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Two files were sampled for mental health clients. The long term care plan clearly outlined issues, early warning signs and interventions to be implemented when the early warning signs occur. A long term care plan has been developed that documents the residents preferences and includes interventions for identified needs including the management of mental health symptoms (link 1.3.6.1). A risk assessment was been completed for both residents on the red risk alert form in the front of the file.</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 there was a change to the residents physical or cognitive health status the RN initiates a medical or nursing review. The record of family correspondence form evidences family notification for changes to resident health status including significant events. Family interviewed confirmed they were always notified of resident health changes.</p> <p>The caregivers and RN's interviewed stated that they had all the equipment referred to in long and short term coordinated care plans necessary to provide care, including hoists, electric beds and pressure relieving equipment.</p> <p>Dressing supplies were available and the medication room holds adequate supplies of wound care products, blood glucose monitoring equipment and other medical equipment. There were no chronic wounds. One skin tear and one bruise (psychogeriatric units) had a short term wound management plan in place and short term care plan.</p> <p>ARHSS D16.4; There is regular specialist input into the treatment and management of residents in the psychogeriatric unit. Strategies for the provisions of a low stimulus environment could be described by the care team and diversional therapist.</p> <p>Five of the seven mental health residents were in the unit that is for more 'able' residents and had access to two spacious lounges and an outdoor area. The units are locked and residents had been assessed as requiring a secure environment. Care plans sampled for mental health residents clearly included interventions to minimise the impact of mental illness.</p>
<p>Standard 1.3.7: Planned Activities</p>	<p>FA</p>	<p>The service employs a qualified diversional therapist (DT). She is supported by an</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>		<p>activity officer and volunteer. Activities are provided Monday to Saturday and are appropriate. The service has a hydrotherapy pool that is well utilised for one to one therapy. Activity plans are individualised and include one to one activities. Regular outings are offered. Mental health residents have the opportunity to attend the community programme. Church services are held on site. Resident meetings are held three monthly. The DT meets with the families at the three monthly multidisciplinary meetings.</p> <p>ARHSS 16.5g.iii: A comprehensive social history is completed on or soon after admission and information gathered from the relative (and resident as able) is included in the activity plan. The activity care plan and 24 hour MDT care plan are reviewed at the same time.</p> <p>ARHSS 16.5g.iv: Caregivers were observed at various times throughout the day diverting residents from behaviours. The programme observed was appropriate for older people with mental health conditions. A group of residents were observed (under DT supervision) in the recreational room involved in activities.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>PA Low</p>	<p>Coordinated care plans are developed by an RN within three weeks of admission and evaluated at least six monthly or if there is a change in health status. There are three monthly multidisciplinary reviews which includes the GP, RN, activities coordinator and any other relevant health professionals involved in the care of the resident. Family/whanau are invited to attend the coordinated care plan reviews. The psychogeriatrician and GP reviews the resident's medication at least three monthly or when requested if issues arise.</p> <p>ARHSS 16.3c: Initial care plans were evaluated by the RN within three weeks of admission.</p> <p>ARHSS 16.4a Care plans are evaluated six monthly or more frequently when clinically indicated</p> <p>There are short term care plans to focus on acute and short-term issues. One mental health file sampled had a short term care plan and the sample was extended by one further psychogeriatric file around these. Both issues were reported as resolved but the short term care plans had not been evaluated.</p>
<p>Standard 1.4.1: Management Of Waste And</p>	<p>FA</p>	<p>There were no chemicals found to be incorrectly labelled. The cleaner's trolley was</p>

<p>Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>		<p>not left unattended. The previous finding has now been addressed.</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>FA</p>	<p>All equipment had a label indicating a current functional check. The previous finding has now been addressed.</p> <p>There is a current building warrant of fitness.</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>	<p>FA</p>	<p>Infection control data is collated monthly and reported to the quality and health and safety meetings. The IC coordinator reports infection control issues, analysis, trends and recommendations. All infections are documented on the infection monthly register. The surveillance of infection data assists in evaluating compliance with infection control practices. Infection rates have been low for example one infection (eye) for December 2014. The quality coordinator conducts benchmarking against The Manor Park Private Hospital infection rates from previous years. 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>	<p>FA</p>	<p>The organisation has policies and procedures around 'not using' restraint. All staff receive training on de-escalation and management of challenging behaviours and there is no evidence to suggest that restraint is used. There is one enabler and no restraint used in the service. The family have consented to the use of the enabler. Challenging behaviours are managed according to plans documented as required.</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 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	PA Low	Medication charts sampled all had photo identification, allergies/adverse reactions, precautions and instructions for administration. GP prescribing meets legislative requirements.	Four of ten medication charts had discontinued medications that had not been dated and signed by the GP.	<p>Ensure all discontinued medications are dated and signed by the GP.</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</p>	PA Low	There were two cooks and four kitchen hands who worked in the kitchen. Some food safety information was included in the orientation package. Food in the fridges and freezer was stored with plenty of room for air to circulate and with	(i) The cook and kitchen hand interviewed have not completed food safety training. (ii) Fridge and freezer temperatures have not been recorded since late December 2014. (iii) There was unlabelled, undated food in the	(i) Ensure all kitchen staff have food safety training. (ii) Ensure fridge and freezer temperatures are being documented. (iii)

legislation, and guidelines.		raw food below cooked food. The fridge had a temperature gauge above the door. However fridge temperatures were not recorded.	fridge (this was rectified for the specific food in the fridge and freezer during the audit). However the finding remains as there was no evidence of a systemic change to ensure the issue does not recur.	Ensure food in the fridge and freezer is labelled and dated. 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	The coordinated care plans identify the nursing problem and describe early warning signs and symptoms/triggers and interventions. A range of assessment tools is completed on admission as applicable including (but not limited to); a) Falls risk assessment tool, b) Norton pressure area risk assessment, c) continence assessment and management plan, d) nutritional plan, f) pain assessment, g) wound assessment and h) behaviour assessment. The manager is experienced in working in mental health services and she and the registered nurses and caregivers ensure that mental health clients receive interventions that meet their assessed needs.	Coordinated care plans did not include the following; (a) known pain was not documented for two of three psychogeriatric residents and the pain assessments had not been reviewed, (b) falls risk assessment outcome (high) and interventions were not reflected in the care plan for a psychogeriatric resident with frequent falls, (c) one psychogeriatric resident with weight loss did not have a fluid balance chart in place or fortnightly weigh completed, (d) one of two mental health residents did not have recurrent syncope, postural hypotension, blood sugar recordings and angina addressed in the care plan and (e) the sample was extended to one further psychogeriatric resident and the care plan did not address the use of an enabler.	Ensure coordinated care plans reflect the resident's current health status. 90 days
Criterion 1.3.8.2 Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and	PA Low	Long term care plans were evaluated on the care plan at least every six months. Short term care plans were sighted in use for wounds and new admissions. They included timeframes for review.	One mental health and one psychogeriatric resident files sampled had short term care plans that had not been evaluated for effectiveness.	Ensure that short term care plans are evaluated. 180 days

progress towards meeting the desired outcome.				
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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.