

Hardwill Group Limited - The Lodge

Introduction

This report records the results of a Provisional 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 The DAA Group 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:	Hardwill Group Limited
Premises audited:	The Lodge
Services audited:	Residential disability services - Intellectual; Rest home care (excluding dementia care); Residential disability services - Physical; Residential disability services – Sensory
Dates of audit:	Start date: 1 February 2017 End date: 2 February 2017
Proposed changes to current services (if any):	Addition of mental health contracted bed.
Total beds occupied across all premises included in the audit on the first day of the audit:	27

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.

General overview of the audit

This provisional audit is conducted at the request of Hardwill Group Ltd. It is a private company set up by a group of people who have had significant experience in the residential aged care sector, including previous ownership and management and development of a number of facilities. They have relevant skills, experience and knowledge to operate The Pyes Pa Country Lodge and have in place a relevant transition plan. They are working closely with the current management to ensure a seamless transition will occur for both residents and staff. They have met with management several times on site to discuss that process.

Pyes Pa Country Lodge provides residential disability (physical, intellectual and sensory) and rest home level care for up to 29 residents. They also hold a contract for one mental health client and wish this service to be included in future contracts. This provisional audit verifies the services ability to provide residential disability mental health services. The service is currently operated by Outrigger Trading Company Ltd and is managed by the two owners and a clinical/facility manager. Residents and families spoke positively about the care provided.

This provisional audit was conducted against the Health and Disability Services Standards and the service's contracts with the district health board and the Ministry of Health. The audit process included review of policies and procedures and residents' and staff files, observations and interviews with residents, families, management, staff, a speech language therapist and a general practitioner. The audit identified two areas for improvement relating to activities and the kitchen, both of which present a low risk to the residents and the prospective providers. Previous areas for improvement identified at the certification audit in 2016 have been addressed.

Consumer rights

The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) is made available to residents. Opportunities to discuss the Code, consent and availability of advocacy services is provided at the time of admission and thereafter as required.

Services are provided that respect the choices, personal privacy, independence, individual needs and dignity of residents and staff were noted to be interacting with residents in a respectful manner.

Resident who identify as Māori or Pacific Island have their needs met in a manner that respects their cultural values and beliefs. Care is guided by a comprehensive cultural policy, Māori health plan and related policies. The service provides support for residents, family/whanau and their extended support networks to promote mental health wellbeing. There is no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. The service works to reduce prejudicial attitudes and discriminatory values. Professional boundaries are maintained.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to formal interpreting services if required.

The service has strong linkages with a range of specialist health care providers, which contributes to ensuring services provided to residents are of an appropriate standard.

The clinical/facility manager is responsible for the management of complaints. A complaints register is maintained and demonstrated that complaints have been resolved promptly and effectively.

Organisational management

The prospective owners were on site and interviewed during the audit. They have had previous governance and management experience in the sector and it is their intention is to continue with the existing planning processes, policies and procedures and workplace staffing while gaining an understanding of the current structure and roles before making any changes.

The current governing body has business and quality and risk management plans documented which include the direction, goals and objectives, philosophy and mission statement of the organisation. Systems are in place for monitoring the services provided, including regular three monthly reporting by the clinical manager to the owners. The facility is managed by an experienced and suitably qualified manager who is a registered nurse.

A quality and risk management system includes an annual calendar of internal audit activity, monitoring of complaints and incidents, health and safety, infection control, restraint minimisation and resident and family satisfaction. Collection, collation and analysis of quality improvement data is occurring and is reported to the regular staff meetings, with discussion of trends and follow up where necessary. Meeting minutes and graphs of quality indicators are well documented. Adverse events are documented on accident/incident forms and seen as an opportunity for improvement. Corrective action plans are being developed, implemented, monitored and signed off when completed. Formal and informal feedback from residents and families is used to improve services. Actual and potential risks are identified and mitigated and the hazard register is up to date.

A suite of policies and procedures cover the necessary areas, including the requirements for a mental health service, are current, and reviewed regularly.

The human resources management policy, based on current good practice, guides the system for recruitment and appointment of staff. A comprehensive orientation and staff training programme ensures staff are competent to undertake their role. A systematic

approach to identify, plan, facilitate and record ongoing training supports safe service delivery, and includes regular individual performance review. Registered nurses are encouraged to undertake post graduate study relevant to their role.

Staffing levels and skill mix meet contractual requirements and the changing needs of residents. The clinical manager is also on call out of hours.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people. Up to date, legible and relevant residents' records are maintained in hard copy.

Continuum of service delivery

The organisation works closely with the local Needs Assessment and Service Coordination Service, to ensure access to the facility is appropriate and efficiently managed. When a vacancy occurs, sufficient and relevant information is provided to the potential resident/family to facilitate the admission.

Residents' needs are assessed by the multidisciplinary team on admission within the required timeframes. Registered nurses are on call 24 hours each day in the facility and are supported by care and allied health staff and a designated general practitioner. On call arrangements for support from senior staff are in place. Shift handovers and communication sheets guide continuity of care.

Care plans are individualised, based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that might arise. All residents' files reviewed demonstrated that needs, goals and outcomes are identified and reviewed on a regular basis. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

The planned activity programme, provides residents with access to a wide range of community activities to meet their preferences and interests. Residents' independence is encouraged and residents are supported to achieve their goals and maintain links with the community. Two facility vans and a car is available for outings.

Medicines are managed per policies and procedures based on current good practice and consistently implemented using a manual system. Medications are administered by registered nurses and care staff, all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of the residents with special needs and likes catered for. Policies guide food service delivery, supported by staff with food safety qualifications. The kitchen was well organised. Residents verified satisfaction with meals.

Safe and appropriate environment

The facility has been purpose built, with a number of additions made over time. All the rooms are single occupancy, including a limited number with shared ensuite bathrooms.

Building and plant complies with legislation and a current building warrant of fitness was displayed. A preventative and reactive maintenance programme is implemented.

Communal areas are maintained at a comfortable temperature. Shaded external areas with seating are available.

Implemented policies guide the management of waste and hazardous substances. Protective equipment and clothing is provided and used by staff. Chemicals, soiled linen and equipment are safely stored. All laundry is undertaken onsite with systems monitored to evaluate effectiveness.

Emergency procedures are documented and displayed. Regular fire drills are completed and there is a sprinkler system installed in case of fire. Access to an emergency power source is available. Residents report a timely staff response to call bells.

The prospective new owners will ensure maintenance and repairs are carried out in a timely way. They do have some plans to upgrade the facility in the future and are aware of the relevant requirements should they proceed with these.

Restraint minimisation and safe practice

The organisation has implemented policies and procedures that support the minimisation of restraint. One enabler was in use at the time of audit and the facility has a 'no restraint' philosophy. Procedures for comprehensive assessment, approval and monitoring process with regular reviews are in place should any episode of restraint become necessary. Enabler use is voluntary for the safety of residents in response to individual requests. Staff receive training at orientation and thereafter as a regular part of the training programme. It includes all required aspects of restraint and enabler use, alternatives to restraint and dealing with difficult behaviours. Staff demonstrated knowledge and understanding of the restraint and enabler processes.

The prospective owners intend to continue with the current philosophy of a restraint free environment.

Infection prevention and control

The infection prevention and control programme, led by two experienced and appropriately trained infection control coordinators, aims to prevent and manage infections. Specialist infection prevention and control advice is able to be accessed from the district health board. The programme is reviewed annually.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education.

Aged care specific infection surveillance is undertaken and analysed. Results are reported through all levels of the organisation. Follow-up action is taken as and when required.

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	43	0	2	0	0	0
Criteria	0	91	0	2	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Pyes Pa Country Lodge (The Lodge) has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.</p>
<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>Nursing and care staff interviewed understand the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form that itemises each aspect consent is sought, including for photographs, outings, invasive procedures, and consent for photographs when on outings. Some residents have denied consent for some things</p>

		<p>and this is noted in the care plan and acknowledged.</p> <p>Advanced care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented where relevant in the resident's record. Staff demonstrated their understanding by being able to explain situations when this may occur.</p> <p>Staff were observed to gain consent for day to day care on an ongoing basis.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters related to the Advocacy Service were also displayed in the facility, and additional brochures were available at reception. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons.</p> <p>Staff were aware of how to access the Advocacy Service and examples of their involvement were discussed with the facility/clinical manager.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' families and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.</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 complaints policy and associated forms meet the requirements of Right 10 of the Code. The information is provided to residents on admission and there is complaints information and forms available in the reception area and on request.</p> <p>The complaints register reviewed showed that 15 complaints have been</p>

		<p>received over the past year. These are all of a minor nature, and actions taken, through to an agreed resolution, are documented and completed within the timeframes specified in the Code. Action plans reviewed show any required follow up and improvements have been made as needed.</p> <p>The clinical/facility manager is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Residents interviewed report being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) through ongoing discussion at residents' meetings, as part of the admission information provided, discussion with staff and regular interaction with community groups. The Code is displayed in common areas together with information on advocacy services, how to make a complaint and feedback forms. An interview with the prospective provider verifies knowledge and understanding of the responsibilities required in relation to adhering to consumer rights legislation.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Residents and families confirmed that services are provided in a manner that has regard for their gender, personal dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff understood the need to maintain privacy and were observed doing so throughout the audit, when attending to personal cares, ensuring resident information is held securely and privately, exchanging verbal information and enabling resident's individual privacy needs to be addressed. All residents have a private room, with some having their own private lounge if required.</p> <p>Residents are encouraged to maintain their independence by being involved in the activities within the Lodge, running the residents' meetings, attendance at community run programmes, participation in clubs, outings and interest groups of their choosing, access to the transportation provided by the facilities two vans and a car and arranging their own visits and appointments. Each residents care plan</p>

		<p>included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for staff, and is then provided on an annual basis, as confirmed in staff and training.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>Staff support the high number of residents in the service who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau to Māori residents. There is a current Māori health plan developed with input from cultural advisers. The plan assesses each individual resident's cultural needs in relation to any specific requirements ie preferences for traditional Maori healing practices. Current access to resources includes the contact details of local cultural advisers, residents' whanau and cultural affiliations. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility. The three Māori residents and their whānau interviewed reported that staff acknowledge and respect their individual cultural needs.</p> <p>The service provides education and support to promote Maori mental wellbeing by encompassing a holistic approach and facilitating active involvement of all relevant stakeholders including community groups, to ensure all residents needs are met.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Residents verified that they were consulted on their individual culture, values and beliefs and that staff respect these. Resident's personal preferences, required interventions and special needs were included in all care plans reviewed. A resident satisfaction questionnaire includes evaluation of how well residents' cultural needs are met and this</p>

		supported that individual needs are being met.
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. A general practitioner also expressed satisfaction with the standard of services provided to residents.</p> <p>The induction process for staff includes education related to professional boundaries and expected behaviours. All registered nurses have records of completion of the required training on professional boundaries. Staff are provided with a Code of Conduct in both the staff orientation booklet and their individual employment contract. Ongoing education is also provided on an annual basis, which was confirmed in staff training records. Staff are guided by policies and procedures and, when interviewed, demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring.</p> <p>Service providers and residents have training on discrimination and barriers to recovery posed by discrimination. Open communication of concerns is encouraged and discrimination issues addressed to aid recovery. Community groups also actively participate in imparting knowledge of barriers to recovery posed by discrimination.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service encourages and promotes good practice through evidence based policies, input from external specialist services, allied health professionals, Health and Disability Support services, services for older people, seating specialists, psychogeriatrician and mental health services, Accident Compensation Commission (ACC) community support groups, occupational therapists and ongoing training updates ie de-escalation strategies</p> <p>The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for onsite and external</p>

		<p>education to support contemporary good practice.</p> <p>Other examples of good practice observed during the audit included the observation of de-escalation strategies.</p>
<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>Residents and family members stated they were kept well informed about any changes to their or their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. There was also evidence of resident/family input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Interpreter services can be accessed via the District Health Board (DHB) when required. Staff knew how to do so, although reported this was rarely required due to all present residents being able to speak English, staff being able to provide interpretation as and when needed, and the use of family members.</p> <p>The use of alternative information and communication methods, are available and used when applicable.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>The business plans which are reviewed and updated annually, outline the purpose, philosophy, scope, direction and goals of the organisation. The documents describe annual and longer term objectives and the associated operational plans. The clinical/facility manager provides a quarterly report against the objectives to the owners. A sample of reports reviewed shows adequate information to monitor performance is reported including operational reports and emerging risks and issues.</p> <p>The service is managed by a clinical manager who holds relevant health professional qualifications and has been in the role for nine years. She is suitably skilled and experienced for the role and has responsibilities and accountabilities defined in a job description and individual employment agreement. The facility manager confirms knowledge of the sector, regulatory and reporting requirements and maintains</p>

		<p>currency through the Nursing Council of New Zealand. The facility manager is supported by the senior registered nurse and the care team who meet regularly.</p> <p>The service holds contracts with the DHB, MoH and ACC for YPD, rest home, long term chronic health conditions and mental health services. 27 residents receive services under the contracts (seven YPD, eight rest home, nine long term chronic medical conditions, one ACC, one mental health and one private paying) at the time of audit.</p> <p>The current governance and management structure will remain in place under the prospective new ownership with a three month lead in time proposed to fully complete the transition process.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>When the clinical/facility manager is absent, the senior registered nurse carries out all the required clinical duties under delegated authority and the owners manage the facility duties. The other registered nurse is also able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well. It is proposed this arrangement will remain in place under new ownership.</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 organisation has a quality and risk system that reflects the principles of continuous improvement and is understood by staff. This includes management of adverse events, complaints, audit activities, a regular resident and family satisfaction survey, monitoring of outcomes, clinical incidents including infections and any medication errors.</p> <p>Terms of reference and meeting minutes reviewed confirmed adequate reporting systems and discussion occurs on quality matters. Regular review and analysis of quality indicators occurs and related information is reported and discussed at the owners and staff meetings. Minutes reviewed included discussion on any pressure injuries, restraints, falls, complaints, incidents/events, infections, audit results and activities. Staff reported their involvement in quality and risk activities through information and input at staff meetings. Relevant corrective actions are</p>

		<p>developed and implemented as necessary and demonstrated a continuous process of quality improvement is occurring. Resident and family surveys are completed annually. The last survey showed a high level of satisfaction with the service.</p> <p>Policies reviewed cover all necessary aspects of the service, including mental health, and contractual requirements and are current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. This is managed by an outside contractor. Staff are updated on new policies or changes to policies through notices and staff meetings.</p> <p>The clinical / facility manager described the processes for the identification, monitoring and reporting of risks and development of mitigation strategies. The risk register shows consistent review and updating of risks, risk plans and the addition of new risks. The manager is aware of, and a staff representative has attended training in, the Health and Safety at Work Act (2015) requirements and has implemented requirements.</p> <p>The prospective owner intends to continue with the contracted policy support service and the current quality process and internal audit activity that is in place.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed show these are fully completed, incidents are investigated, action plans developed and actions are followed-up in a timely manner. Adverse event data is collated, analysed and reported to the owners and staff and meeting minutes reviewed show discussion in relation to trends, action plans and improvements made.</p> <p>Policy and procedures described essential notification reporting requirements (pressure injuries, health and safety, human resources, infection control, the coroner, the DHB). The clinical/facility manager advised there has been one notification of a significant event made to the Ministry of Health since the previous audit. This followed the</p>

		<p>required process and was managed appropriately.</p> <p>The prospective owner confirmed knowledge and understanding of the legislative and compliance issues impacting on this service.</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>Policies and procedures, in line with good employment practice and relevant legislation, guide human resources management processes. Position descriptions reviewed were current and defined the key tasks and accountabilities for the various roles. The recruitment process includes police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are systematically maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role and included support from a 'buddy' through their initial orientation period. Staff records reviewed show documentation of completed orientation and a performance review after a six weekly to three-month period.</p> <p>Continuing education is planned on a biannual basis. Mandatory training requirements are defined and scheduled to occur over the course of the year. Care staff have either completed or are enrolled in a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. A staff member is the internal assessor for the programme. Education records reviewed demonstrated completion of the required training. Staff reported that the annual performance appraisal process provides an opportunity to discuss individual training needs, supervision requirements and review competencies. Appraisals were current for all staff.</p> <p>All staff have completed recent training in working with people with mental health conditions and the registered nursing team are comprehensive trained to cover relevant mental health requirements.</p>
<p>Standard 1.2.8: Service Provider Availability</p>	FA	<p>There is a documented rationale for determining staffing levels and skill</p>

<p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>mixes in order to provide safe service delivery. The facility adjusts staffing levels to meet the changing needs of residents, supported by the use of a staffing rationale documented process. The minimum number of staff is provided during the night shift and consists of one caregiver. An afterhours on call roster is in place, with staff reporting that good access to advice and support if required is available. Care staff reported adequate staff were available and that they were able to complete the work allocated to them. This was further supported by residents and family interviewed. Observations and review of a two week roster cycle sample during this audit confirmed adequate staff cover has been provided. The organisation uses a bureau for short notice roster gaps. At least one staff member on duty has a current first aid certificate and there is RN coverage daily as well as on call at all times.</p> <p>The prospective owner intends to continue with the roster system that is in place and there are no changes intended to the current clinical and care staff.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The resident's name, date of birth and National Health Index (NHI) number are used on labels as the unique identifier on all residents' information sighted. All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site.</p> <p>Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for</p>	<p>FA</p>	<p>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and meet</p>

<p>services has been identified.</p>		<p>with the facility manager/clinical manager. They are also provided with written information about the service and the admission process.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements.</p> <p>Entry to residents requiring mental health services is co-ordinated by the service, the mental health team and their community support team. A comprehensive plan is implemented that identifies and manages potential risks. The mental health team provides twenty four hour support and back up should a situation eventuate that requires immediate intervention.</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>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses a dedicated transfer form to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family. At the time of transition between services, appropriate information, including medication records and care plan is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility showed the process to be well planned and co-ordinate. Family of the resident reported being kept well informed during the transfer of their relative.</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>	<p>FA</p>	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care and Medicine Management Guide for Community, Residential and Facility-based Respite Services - Disability, Mental Health and Addiction.</p> <p>A safe system for medicine management was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each</p>

		<p>stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by a registered nurse against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three monthly GP review is consistently recorded on the medicine chart.</p> <p>There are no residents who self-administer medications at the time of audit. However, processes are in place to ensure residents wishing to self-administer and deemed competent to do so by the GP, have this managed in a safe manner.</p> <p>Medication errors are reported to the facility/clinical manager and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process is verified.</p> <p>Standing orders are not used.</p> <p>Interviews verify continuity of treatment for mental health residents is promoted, by ensuring the views of the resident, family/whanau and other relevant service providers are considered prior to administration of new medicines or medical interventions.</p>
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management	PA Low	The food service provided is in line with recognised nutritional guidelines to meet the needs of older people, however the menu also addresses

<p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>the requests of the needs of the younger residents (for example hamburgers and chips). The menu follows summer and winter patterns and has been reviewed by a qualified dietitian in October 2016 Recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, transportation, delivery and disposal comply with current legislation and guidelines, except for the chiller which requires some attention. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cooks have undertaken safe food handling qualifications.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Residents have access to food and fluids to meet their nutritional needs always. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and residents' meetings minutes. Resident interviews mentioned that the cook will cook them something different if they do not like what is being served. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed with the facility manager. There is a clause in the access agreement related to when a resident's placement can be terminated.</p>

<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>Information is documented using validated nursing assessment tools, such as pain scale, falls risk, skin integrity, nutritional screening and depression scale, as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident related information. All residents have current interRAI assessments completed by one of two trained interRAI assessors on site.</p> <p>Cultural assessments where appropriate, are facilitated in conjunction with traditional healers.</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>Plans reviewed are person centred, developed with the person and includes wellbeing, community participation, and meeting the residents' physical and mental health needs. Plans reflected the outcomes of the integrated assessment process and other relevant clinical information. In particular, the needs identified by the interRAI assessments are reflected in the care plans reviewed.</p> <p>Care plans evidence service integration with progress notes, activities notes, and medical and allied health professional's notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.</p> <p>Relapse planning was sighted in the resident with mental health needs. The plan was developed with the involvement of the resident, the clinician and the resident's whanau. The relapse plan identified early warning signs, relapse prevention and associated management strategies.</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>FA</p>	<p>Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The</p>

		<p>GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.</p> <p>Residents receiving mental health services have services that promote minimal restrictions and intrusion. Observation, documentation and interviews verify the service works collaboratively to promote mental health and wellbeing and to limit the onset of mental illness.</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>	<p>PA Low</p>	<p>The activities programme is provided by two activities co-ordinators who are overseen by an occupational therapist.</p> <p>Independence and community involvement is encouraged at the Lodge. Most of the residents leave the Lodge each day to participate in a range community organized recreation, work, leisure, cultural, education and community events activities, to attend appointments, go shopping, meet up with friends or family or go on an outing. Attendance at community organised activities is based on residents' preferences, interests or previous arrangements in place prior to entry. Two vans and a car are available to provide transportation for residents as required.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated six monthly and as part of the formal six monthly care plan review.</p> <p>Residents who choose not to attend outings have activities provided in house, however there was no planned monthly activities programme sighted. Residents were observed to be assisting in the daily chores (eg, folding washing, laying tables, doing the garden, collecting the mail) and a bible studies group is run by residents for residents.</p> <p>Offsite activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. The residents run the monthly resident's</p>

		meetings, however interviews verify satisfaction with activities has never been discussed. The monthly newsletter is put together on a computer by a resident and includes an update on what is happening in regards to the Lodge. Resident and family satisfaction surveys demonstrated satisfaction with the programme.
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations, occur every six months in conjunction with the six-monthly interRAI reassessment or as residents' needs change. Evaluations are documented by the RN, and for mental health residents include a range of outcome measures and input from a range of stakeholders. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples were sighted of short term care plans being consistently reviewed for infections and progress evaluated as clinically indicated (daily, weekly or fortnightly) and according to the degree of risk noted during the assessment process. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a 'house doctor', residents may choose to use another medical practitioner. Residents are frequently taken to see the doctor rather than the doctor coming on site. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files. Referrals are followed up on a regular basis by the registered nurse or the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.</p>

<p>Standard 1.4.1: Management Of Waste And 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>FA</p>	<p>Documented processes for the management of waste and hazardous substances were in place. Infection control documentation includes a waste management section detailing procedures for waste (blood and bodily fluids) management and disposal.</p> <p>The doors to the areas storing chemicals were secured and containers labelled. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur. Any related incidents are reported in a timely manner.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using these, including gloves, aprons and boots.</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>A current building warrant of fitness (expires 29 June 2017) is publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose. There is a proactive and reactive maintenance programme and buildings, plant and equipment are maintained to an adequate standard. The testing and tagging of equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed and observation of the environment.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting. The environment is adequate for the range of activities undertaken in the areas. Efforts are made to ensure the environment is hazard free and that residents are safe. Residents interviewed confirmed they are happy with the environment.</p> <p>The prospective owners have initial plans to extend the service and improve the environment. They understand the legal requirements and issues if these go ahead and have had relevant previous experience to inform any changes.</p>

<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There is a mix of toilet and showers facilities. This includes a small number of rooms with shared bathrooms and additional bathrooms and toilets. There are adequate numbers of accessible bathrooms and toilets throughout the facility. Appropriately secured and approved handrails are provided in most of the toilet/shower areas, and other equipment/accessories are available to promote resident independence.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation. Rooms are personalised with furnishings, photos and other personal items displayed.</p> <p>There is room to store mobility aids walking frames and wheel chairs. Those residents who use mobility aids have the larger bedrooms to ensure their independence is supported. Residents reported they are happy with their personal areas.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Communal areas are available for residents to engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents are able to access areas for privacy, if required. Furniture is appropriate to the setting and resident needs. It is arranged in a manner which enables residents to mobilise freely.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>All laundry is undertaken on site in a dedicated laundry. Resident's personal items are laundered on site. There is also a washing machine available in a separate area for residents to do their own washing if they wish. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner if they do not do it themselves. The facility laundry is currently washed by care staff who demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen.</p> <p>There is a small designated cleaning team who has received</p>

		appropriate training. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers. Cleaning and laundry processes are monitored through the internal audit programme.
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service on the 12 April 2005. A trial evacuation takes place six-monthly and they liaise with the New Zealand Fire Service during these. The most recent trial was in August 2016. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, gas burners, glo sticks and torches, were sighted. These meet the requirements for the 27 residents. A water storage tank is located in the complex, and a generator is able to be hired from a local source. An independent power source is also available to power the phone system if an emergency should occur. Emergency lighting is regularly tested.</p> <p>Call bells alert staff to residents requiring assistance. Residents and families reported staff respond promptly to call bells.</p> <p>Appropriate security arrangements are in place. All doors and windows are checked and locked by staff at night.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All residents' rooms and communal areas have large opening external windows. A number have doors that open onto outside garden or patio areas. Electric heating provided is provided with panel heaters in all rooms and communal areas and fan heaters in bathrooms. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.</p>

<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>The service provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a comprehensive and current infection control manual developed at organisational level. The infection control programme and manual are reviewed annually (last reviewed in December 2016).</p> <p>The facility manager/clinical manager and the RN are the designated IPC coordinators, whose roles and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the facility manager/clinical manager. Any concerns are addressed immediately at handover. Results of surveillance data is tabled at the quarterly quality/staff meeting. Evidence verifies incidents of infections are low. Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these related responsibilities.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The infection prevention and control coordinators have appropriate skills, knowledge and qualifications for the role, and has been in this role for two years. Both have undertaken attended relevant study days in infection prevention and control and as verified in training records sighted. Well-established local networks with the infection control team at the DHB are available, as is access to IC training by an external provider. The coordinators have access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The IPC coordinators confirmed the availability of resources to support the programme and any outbreak of an infection.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control</p>	<p>FA</p>	<p>The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in December 2016 and include</p>

<p>of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>		<p>appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves, as appropriate to the setting. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>Priorities for staff education are outlined in the infection control programme annual plan. Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by suitably qualified registered nurses, and the infection control coordinator. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response.</p> <p>Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell and increasing fluids during hot weather.</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>Surveillance is as recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. When an infection is identified, a record of this is documented on the infection reporting form/clinical record. The infection control coordinators review all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year, and comparisons against previous years.</p>

		<p>New infections and any required management plan are discussed at handover, to ensure early intervention occurs. Surveillance results are then shared with staff at general staff meetings, as confirmed in meeting minutes sighted and interviews with staff.</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>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The facility has a restraint free environment.</p> <p>The restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and her role and responsibilities.</p> <p>On the day of audit, one resident was using an enabler, which was the least restrictive and used voluntarily at their request. A similar process is followed for the use of enablers as is used for restraints as appropriate. This provides for a robust process which ensures the on-going safety and wellbeing of the resident.</p> <p>Restraint would be used only a last resort when all alternatives have been explored. This was evident on review of the restraint/enabler register and the file reviewed of the resident who has the approved enabler.</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 1.3.13.5</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.</p>	PA Low	All aspects of food procurement, production, preparation, transportation, delivery and disposal comply with current legislation and guidelines, except for the chiller which requires some attention. The shelves and walls in the chiller are painted. The paint is chipped, difficult to wipe clean and is pervious to spills and moisture. The linoleum on the floor is incomplete with torn pieces missing.	The food chiller does not provide non-pervious surfaces on the shelves, walls and flooring for safe food storage.	<p>Storage of food complies with safe food guidelines.</p> <p>30 days</p>
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the</p>	PA Low	There is no planned activities programme sighted that details the activities which are being provided in-house for residents who choose or are unable to go out. Residents are unaware of what activities are occurring each day, as are family and staff.	Activities at the Lodge are planned and provided with residents attending a range of community events. However, there is no documented evidence of a planned programme for those residents	There is evidence to show activities are planned and provided to maintain all residents' skills, interests and resources.

consumer.			that do not go out.	30 days
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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.