

Hardwill Group Limited - The Lodge

Introduction

This report records the results of a Partial Provisional Audit; Certification 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 - Psychiatric; Residential disability services – Sensory
Dates of audit:	Start date: 6 December 2017 End date: 7 December 2017
Proposed changes to current services (if any):	Addition of hospital (geriatric) level care to the scope of certification
Total beds occupied across all premises included in the audit on the first day of the audit:	26



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

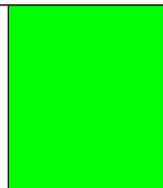
The Lodge provides residential disability services (intellectual, physical, sensory and psychiatric) and rest home level care for up to 29 residents. The service is operated by the Hardwill Group Ltd and managed by a clinical manager. Since the previous audit significant improvements have been made to the environment, both internal and external, with plans in place for further improvements. The facility has also applied to extend their service to include hospital level care, and two hospital beds, to cater for those longer-term residents whose needs increase as they age, so they can still be cared for at the facility. This has been in response to requests from both families and residents, who spoke positively about the care provided.

This certification and partial provisional audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board and the Ministry of Health. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, management, staff, the directors and two general practitioners.

This audit has resulted in two areas requiring improvement, in relation to the request for the addition of hospital level residential care services. These relate to staffing levels and the door widths for the proposed dual-purpose rooms.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.



Standards applicable to this service fully attained.

Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Services are provided that support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent.

Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. There is no evidence of abuse, neglect or discrimination.

The service has linkages with a range of specialist health care providers to support best practice and meet resident's needs.

A complaints register is maintained with complaints resolved promptly and effectively.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Business and quality and risk management plans include the scope, direction, goals and objectives, philosophy and mission statement of the organisation. Monitoring of the services provided to the governing body is regular and effective. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved, and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and are current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery, and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

Residents' information is accurately recorded, securely stored and is not accessible to unauthorised people.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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The entry into The Lodge service is facilitated by comprehensive entry processes and guidelines that ensures all needs and requirements have been considered. Support plans are completed with residents soon after entering the service and based on referrals, needs assessment and standardised assessments available to staff. Support plans were current and regularly reviewed. Support planning incorporates the requirements of the continuum of service delivery standard and all planning is completed in hard copy and stored safely in a locked office. The residents have risk and crisis management plans where needed.

All aspects of peoples' health, wellbeing, interests and activities are incorporated into the file.

Medicine management is completed safely. There is oversight by qualified clinical staff and staff who administer medicines have the required medication competencies with appropriate training and information available.

The residents are supported to maintain healthy lifestyles, enjoy nutritious meals and eat healthily. Residents with specific dietary requirements are supported, depending on each individual need. Menu plans are based on appropriate nutritional guidelines. Residents have access to a good supply of food and drinks of their choice at all times and are provided with support to enjoy their meals as required. There are several areas for dining made available.

Safe and appropriate environment

<p>Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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The facility meets the needs of residents and was clean and well maintained. There is a current building warrant of fitness. Electrical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken onsite and evaluated for effectiveness.

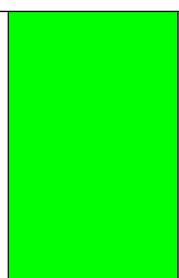
Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised. Residents reported a timely staff response to call bells. Security is maintained.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The organisation has policies and procedures that support the minimisation of restraint. There were no restraints or enablers in use at the time of audit and the facility maintains a restraint free environment. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The Lodge is a well-managed environment for infection prevention and control which is appropriate for the size and scope of the facility. Infection prevention and control is led by experienced and trained designated staff. The programme is reviewed annually

with specialist advice accessed when needed. Staff demonstrated good principles around infection control which is guided by policies, procedures and regular education updates and information. Surveillance is undertaken and the results are reported through to the staffing teams. 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>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/choice, 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. Staff interviewed could articulate clearly the requirements of the Code.</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 understood the principles and practice of informed consent citing examples of how they do so in practice. Staff were observed to gain consent for day to day care. Informed consent policies provide relevant guidance to staff. Seven clinical files reviewed demonstrated that informed consent has been gained appropriately using the organisation's standard consent form. Advance care planning, 'wishes on death' and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented, as appropriate, in the resident's record.</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>	<p>FA</p>	<p>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service were also displayed and available in the facility. 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>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>	<p>FA</p>	<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. The facility has unrestricted visiting hours and encourages visits from residents' family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff. Family members spoke about being invited to celebrations and that they were very happy with the service provided. There was evidence of community interaction both in house and externally. Self-help and autonomy is encouraged and was observed at the time of audit.</p> <p>The service is responsive to young people with disabilities accessing the community, resources, facilities and mainstream supports. The service promotes access to family and friends.</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>	<p>FA</p>	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so. Complaint forms are also available in the reception area.</p> <p>The complaints register reviewed showed that five complaints have been received over the past year and that actions taken, through to an agreed resolution, are documented and completed well within the timeframes. Action plans show any required follow up and improvements have been made where possible. The clinical 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. There have been no complaints received from external sources since the previous audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>Residents interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) by the staff and on moving into the facility when they received the information pack. Those interviewed stated clearly it was the registered nurse who advised them. The Code is displayed in several areas within the facility including the entrance way, together with information on advocacy services, how to make a complaint and feedback forms. Leaflets were visibly available. Family members concurred that they also were made aware of and</p>

		understand what to do and what to expect for their family member.
<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 they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices. All voiced they could articulate their needs in these areas and staff would respond. Staff were observed to respect the residents' rooms by knocking before entry. The chaplain attended the facility on the second day of audit to meet with identified residents.</p> <p>Staff were observed to maintain privacy throughout the audit. All residents have a private room that reflects their individual personal items and this is set up as they like the room to be.</p> <p>Residents are encouraged to maintain their independence by attending activities of choice from a comprehensive programme. Residents and family interviewed voiced they had many opportunities both within and outside of the facility to maintain their independence, with one resident out at work for the week. It was evident throughout the audit that residents were participating in clubs and outings of their choosing. Care plans included documentation related to the resident's abilities, and strategies to maximise independence. The service has invested in the Golden Care on line activity programme which identified plans that reflected individuality and choice.</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. The activities coordinator progress notes were also sighted.</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 was confirmed to occur during orientation and annually.</p> <p>Young people with disabilities are able to maintain their personal, gender, sexual, cultural, religious and spiritual identity.</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 residents in the service who identify as Māori to integrate their cultural values and beliefs. The importance of whanau connection was articulated and evidenced in files including the use of a family/whanau contact sheet. Māori residents and their whānau interviewed reported that staff acknowledge and respect their individual cultural needs. It was evidenced in the files that staff identify iwi and hapu affiliations.</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 respected these by using their preferred salutation. Resident's personal preferences, required interventions and special needs were included in care plans reviewed including affiliations, religious denominations and food preferences. The resident satisfaction survey confirmed that individual needs are being met.</p>
<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. Staff voiced they received education related to professional boundaries, expected behaviours and the Code of Conduct. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.</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 regular input from external specialist services and allied health professionals, for example, diabetes nurse specialist, wound care specialist, psychogeriatrician and mental health services for older persons. External specialists provide in service education to staff which staff spoke highly of and agreed was adding value to residents' care. The general practitioners (GP) interviewed confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests. Both spoke of their admiration for the facility in managing the complexities of their residents.</p> <p>Staff reported they receive management support for external education and the RN accesses professional networks to support good practice having recently completed post graduate studies.</p> <p>Other examples of good practice observed during the audit included the clinical manager and registered nurse interaction with specialist services at the hospital, their strong advocacy for their residents, and use of clinical data to support their discussion.</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/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. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. This was observed during the audit.</p> <p>Staff know how to access interpreter services, although reported this was rarely required due to all</p>

		<p>residents speaking English. Staff are able to provide interpretation as and when needed or know how to access services. They gave examples of using services through the DHB and also using family input.</p> <p>Language and communication needs and use of alternative information/communication methods were available.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>The strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The documents described annual and longer term objectives and the associated operational plans. The organisation's philosophy and business planning reflects a person/family centred approach. A sample of the regular meetings with the owners showed adequate information to monitor performance is reported including occupancy, emerging risks and quality information. The owners, who are new to the facility this year, are also on site daily to provide additional support and assistance to the manager.</p> <p>The service is managed by a clinical manager who holds relevant qualifications, is a registered nurse and has been in the role since March. She also managed the facility for the previous owners. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The clinical manager confirms knowledge of the sector, regulatory and reporting requirements, maintains currency through the New Zealand Nursing Council and has also completed post graduate qualifications.</p> <p>The service holds contracts with the DHB, ACC and the MoH for residential aged care (rest home); YPD – residential non-age care; long term chronic health conditions (LTCH); and psychiatric residential care. Twenty six (26) residents were receiving services under the contracts at the time of audit. Eight aged residential care; one psychiatric disability; eight YPD; one ACC and nine LTCH.</p> <p>Partial Provisional: The owners have developed a transitional plan for the addition of hospital level care. No changes will be required in the governance or the current management structure due to the limited number of beds being applied for. Sufficient time has been allowed for an appropriate 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</p>	FA	<p>When the clinical manager is absent, the registered nurse carries out all the required duties under delegated authority. During absences of the senior registered nurse, the clinical management is overseen by the manager who is also a registered nurse and experienced in the sector and able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well. The owners are also available on call to address any non-clinical management issues.</p>

<p>effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>		<p>Partial Provisional: Plans are in place to ensure any absences by rostered registered nurses will be able to be covered by existing registered staff and by new staff who will be employed prior to the provision of the new service. The current manager has extensive experience in the aged care sector and understands the requirements of a hospital level care service.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes the management of incidents and complaints, audit activities, a regular resident/family satisfaction survey, monitoring of outcomes, clinical incidents including infections, training and health and safety reporting.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the management team meetings with the owners and at the regular staff meetings. Staff reported their involvement in quality and risk management activities through the audit activities, staff meetings, the daily communication folder and the daily handovers, as well as a range of informal discussions which are a regular feature due to the smaller size of the facility. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually. Residents meetings are held monthly and are chaired and organised by one of the younger residents. Minutes evidence good communication between the service and all the residents, many of whom are younger. The chair confirmed all requests are actioned promptly. A recent request was for a dryer in the residents' laundry. This has now been purchased.</p> <p>Younger residents live throughout the facility rather than being all together in one area and they reported this was their choice and the atmosphere in the facility is one of a large family with individuals choosing their own spaces. All residents, including the younger people, have relevant electronic equipment and the necessary aids to help mobility and independence.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The clinical manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements.</p> <p>Partial Provisional: The current annual quality plan and established quality management system will meet requirements for the new service.</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 showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to the management and staff.</p> <p>The clinical manager described essential notification reporting requirements, including for pressure injuries. She advised there have been no notifications of significant events made to the Ministry of Health or any other external authorities since the previous audit.</p> <p>Partial Provisional: There are no legislative compliance issues identified that would affect the new 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>	<p>FA</p>	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, 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 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, along with the buddy programme which provides additional support. Staff records reviewed show documentation of completed orientation and a performance review after an 11-week period.</p> <p>Continuing education is planned on a biannual basis, including mandatory training requirements. The Western Bay of Plenty Primary Health Organisation (PHO) provides monthly training courses which care staff regularly attend. Hospice also provide relevant education courses. Most care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. The clinical manager is the internal assessor for the programme. There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.</p> <p>Partial Provisional: The provider has included a training plan in their transitional plan to upskill all care staff to meet the requirements of a new contract for hospital level care.</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>PA Low</p>	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week to the current residents. The facility adjusts staffing levels to meet the changing needs of residents – using tools, assessed need levels and consultation with staff. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of a two-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate.</p> <p>Partial Provisional: Additional staffing will be needed to meet the requirements for hospital level care.</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>All files sampled included the required demographic, personal, health and clinical information. There was clear evidence of integrated, current clinical notes with the GPs and Allied health services. There was clear correlation of the inter-rai assessment findings throughout the documentation. Records were legible with the name and designation of the person making the entry was legible.</p> <p>There was evidence of secured archived files and were easily retrievable through a documented system. Residents' files are held for the required period before being destroyed. There was no evidence of personal or private resident information on public display at time of 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 services has been identified.</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 are 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. Service charges comply with contractual requirements.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</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 the DHB's 'yellow envelope' system to facilitate transfer of residents to</p>

<p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>		<p>and from acute care services. There is open communication between all services, the resident and the family/whānau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the progress notes. It was observed on several occasions throughout the audit that staff preferred to pick up residents when ready for discharge from hospital as opposed to sending them home alone in a taxi. 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. A safe system for medicine management (using a roll system) was observed on the days of audit. This was changed from a blister pack system recently and staff report this is much easier to use. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each 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. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided weekly.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six monthly stock checks and accurate entries.</p> <p>There were no medications stored in the fridge but there was evidence of thermometer and templates for monitoring when necessary.</p> <p>Good prescribing practices noted included 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 was consistently recorded on the medicine chart. Standing orders are used, were current and comply with guidelines. The GP commented that the RN was very efficient in ensuring all prescribing complied with standards.</p> <p>There were no residents who were self-administering medications at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner, should it be required.</p> <p>There is an implemented process for comprehensive analysis of any medication errors and there was evidence of these being feedback to staff. Consideration is being given to an electronic system which the GP is supportive of.</p> <p>The Lodge had no residents self medicating at the time of the audit .There was clear evidence of a</p>

		<p>system in place should this be required.</p> <p>The current medication system is appropriate for hospital level care.</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>	FA	<p>The food service is provided on site by two cooks and a kitchen team, and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented. The menu rotates six weekly.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cooks have undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</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. Special equipment, to meet resident's nutritional needs, is available. The staff interviewed stated they are informed by the RN of any dietary changes and they follow up with the resident to ensure things are of a satisfactory nature for them.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided. Any concerns/complaints regarding food are dealt with quickly and efficiently. At time of the audit several comments were heard about how good the food is and how much they enjoy it. The residents have choice and can ask for extras at any time. There is ample supply of food to cater in between food services.</p> <p>The nutritional management and catering is suitable for the provision of hospital level care.</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</p>	FA	<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. There is a clause in the access agreement related to when a resident's placement can be terminated.</p>

family/whānau is managed by the organisation, where appropriate.		The registered nurse provided examples, including wandering risk, higher care level is required, suicidal ideation, and significant risk to others - aggressive behaviour.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Information is documented using validated nursing assessment tools such as pain scale, falls risk, skin integrity, nutritional screening and wound management as a means to identify any needs/cares 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 the trained interRAI assessors on site (two). These are predominately undertaken by the RN on site with support from the clinical manager. Residents and families confirmed their involvement in the assessment process.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed. Care plans are comprehensive and evidence service integration with progress notes, activities notes, and medical and allied health professionals' 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. Cultural needs were evident and reflective of needs and values.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Documentation, observations and interviews verified the provision of care provided to residents was person centred, consistent with their needs, goals and the plan of care. The facility caters for a diverse range of resident's individualised needs, as was evident in all areas of service provision. The two GPs interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of an excellent standard. Both voiced that this facility was catering for a very complex resident base and did so well. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the types of care provided and in accordance with the residents' needs. Over the course of the audit there were several occasions of the linkage and communication between the facility and Mental Health Services and required follow up actioned immediately by the staff member informing resident, family and staff of the information received.
Standard 1.3.7: Planned Activities Where specified as part of the	FA	The activities programme is provided by an activities coordinator and a volunteer. They have recently implemented an online programme – Golden Carers - that informs their activities programme and

<p>service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>planning. Information gathered included a social assessment and history 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. There was clear evidence of this on file in the progress notes. The resident's activity needs are regularly reviewed and evaluated three-monthly and as part of the formal six monthly care plan review.</p> <p>Activities highlighted are reflective of the residents' goals, ordinary patterns of life and included internal and external community activities. Social connection is a focus and this was evidenced on site with the number of residents leaving to attend community programmes. Individual, group activities and regular events are offered. Residents and families/whānau are involved in evaluating and improving the programme through residents' group meetings (chaired by a resident), satisfaction surveys and individual resident meetings. Younger people with disabilities have their needs met and one of the younger people supported was at their work place of choice.</p> <p>Residents interviewed confirmed they find the programme extensive, fun and 'there is always something to do'. In the absence of the activities coordinator, there is a programme for the caregivers to follow and this ensures that something is offered over the weekends. Residents are encouraged to participate. There was evidence of a balanced approach to activities both internally and externally.</p> <p>Partial provisional: The programme offered both from a group and individual perspective is suitable for Hospital Level care as activities are tailored to individual needs and goals.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<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 or clinical manager. Formal care plan evaluations, occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. The service responds by initiating changes to the plan of care if the progress anticipated is not realised. There were several examples of short term care plans being consistently reviewed as clinically indicated and the progress evaluated for infections, wounds and falls, for example. Any unresolved needs that require further action/intervention are transferred to the individual's long term care plan. The timeline outlining the need/issue was reviewed, updated and interventions changed demonstrate a timely response to the issue. 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>FA</p>	<p>Residents are supported to access or seek referral to other health and/or disability service providers. The facility has access to four GPs, with residents given the choice to either use these or go to another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. This was evidenced during the audit. Copies of</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>		<p>referrals were sighted in residents' files (eg, psychogeriatrician, dietician). The resident and the family/whānau 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>Staff follow documented processes for the management of waste and infectious and hazardous substances. 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.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this.</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 (expiry date 29 June 2018) is publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. The environment is hazard free, residents are safe and independence is promoted. External areas are safely maintained and are appropriate to the resident groups and setting. These have all been recently upgraded to provide additional shelter and communal areas.</p> <p>Residents confirmed they know the processes they should follow if any repairs or maintenance is required, any requests are appropriately actioned and that they are happy with the environment. Sufficient equipment is available, and personal equipment for the younger residents is not used for other residents. The facility is fully accessible to meet the mobility and equipment needs of all people receiving services.</p> <p>Partial Provisional: No environmental changes are planned for the new service that will require any new compliance requirements.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p>	<p>FA</p>	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes a range of bathroom sizes to accommodate all resident's needs. Appropriately secured and</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>		<p>approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote resident independence. Upgrades of a number of areas have been completed since the last audit with further planned improvements to occur.</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>	<p>PA Low</p>	<p>Adequate personal space is provided to allow current 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 and wheelchairs. No residents have scooters but there is adequate storage room should this be required. Staff and residents reported the adequacy of bedrooms.</p> <p>Partial Provisional: Room sizes are appropriate, however current door widths in the rooms planned for hospital level care are not adequate.</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>	<p>FA</p>	<p>Communal areas are available for residents to engage in activities. The dining and several lounge areas are spacious and enable easy access for residents and staff. Residents can access a number of internal and external areas for privacy, if required. Furniture is appropriate to the setting and residents' needs. There is consideration of compatibility with other residents for all the younger residents. The inclusion of the newly refurbished upstairs area which accommodates some residents with a need for more privacy and independence, is a responsive initiative.</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>	<p>FA</p>	<p>Laundry is undertaken on site in a dedicated laundry by rostered staff. Residents have their own laundry which is used by those more independent residents. Care staff demonstrated a sound knowledge of the laundry processes, dirty to clean flow and handling of soiled linen. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner.</p> <p>There is a small designated cleaning team who have received appropriate training. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers. The level of cleanliness at the facility was particularly high.</p> <p>Cleaning and laundry processes are regularly monitored through the internal audit programme.</p>

<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>	<p>FA</p>	<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 described 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 27 November 2017. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent planned evacuation was in August 2017, with a further evacuation completed the week of the audit due to a false alarm caused by an insect in a detector. This was completed efficiently. 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, blankets, mobile phones and gas BBQ's were sighted and meet the requirements for the 26 residents. Large water storage tanks are located at the complex, and there is a generator available for hire nearby. Emergency lighting is regularly tested.</p> <p>Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and residents and families reported staff respond promptly to call bells.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and checked on handover to the night staff.</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>	<p>FA</p>	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows and doors that open onto outside garden or patio areas. Heating is provided with electric heating in residents' rooms and in the communal areas. 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</p>	<p>FA</p>	<p>The service implements an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual, with the facility recently obtaining the services of an external infection control specialist service to help inform best practice. The infection control programme and manual are reviewed annually.</p> <p>The clinical manager/registered nurse share the responsibility of IPC coordinator, with roles and</p>

<p>be appropriate to the size and scope of the service.</p>		<p>responsibilities defined in a job description. Infection control matters, including surveillance results, are reported monthly to the management team, the staff team and residents, where relevant</p> <p>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 responsibilities and this was confirmed by the RN</p> <p>Partial provisional audit: The current infection prevention and control system is appropriate for hospital-level care.</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 IPC coordinators have appropriate skills, knowledge and qualifications for the role, and has been in this role for several years. The RN has been in role for two years and shares the responsibility with the clinical manager. They have attended external and in-service training in infection prevention and control and attended relevant study days at the DHB and PHO, with support from the infection control team at the DHB, the community laboratory, the GP and public health unit, as required. Diagnostic results are responded to immediately to ensure timely treatment and resolution of any infections. This was observed occurring on the days of the audit.</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 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>FA</p>	<p>The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. Those sighted included 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. 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>Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by the suitably qualified coordinators. Content of the training is documented and was current and understood by staff. 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. There was evidence in a staff communication book of updates, new information and training</p> <p>The results of audits - handwashing, cleaning, for example, are well documented and shared with staff and residents with appropriate action taken (eg, additional training), and followed up for desired outcome.</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. Staff stated they reinforce the washing of hands with the residents as this is an area that they often forget to do. The resident meeting is an avenue that the clinical manager and RN utilise to emphasise the key messages and audit findings.</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 appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract. The clinical manager reviews all reported infections and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>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. The close monitoring offers some assurance that infection rates in the facility are well managed and addressed. There was a consistent practice of 12 months of data evidenced.</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 restraint coordinators (the registered nurse and the clinical manager share the role) provide 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. Annual organisational reviews occur, and restraint is a part of the regular quality programme should this be required.</p>

		<p>On the day of audit, no residents were using any restraints or enablers. Restraint is used as a last resort when all alternatives have been explored. This was evident from interviews with staff who are actively involved in the ongoing process of minimisation which has seen this facility having no use of restraint for a number of years. Regular training occurs in de-escalation techniques and working with people with challenging behaviours. Staff were observed using these during the audit.</p>
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Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.8.1</p> <p>There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>	PA Low	The Lodge is planning to provide hospital level care in their facility. To do this there needs to be an increase in the level of registered nursing coverage to meet legislative requirements as the current levels are not sufficient. There is no 24-hour RN coverage or any RNs at the weekends, other than on call. A process is underway to address this.	There are currently not sufficient staff employed to provide registered nursing coverage as required for the provision of hospital level care.	<p>Ensure the level of RN coverage meets legislative and contractual requirements and the needs of the residents prior to providing the higher level of care.</p> <p>Prior to occupancy days</p>
<p>Criterion 1.4.4.1</p> <p>Adequate space is provided to allow the consumer and service provider to move safely around their personal space/bed</p>	PA Low	Partial provisional: The current door widths on the two rooms that are planned to become dual purpose rooms are 870mm for the ranch sliders and 810mm for the doorways. These will not allow	The doorways of the rooms intended to provide hospital level care need to	Ensure doorways of the allocated rooms meet requirements for the provision of the higher level

<p>area. Consumers who use mobility aids shall be able to safely maneuver with the assistance of their aid within their personal space/bed area.</p>		<p>a bed to be moved through if required.</p>	<p>be widened to allow any safe exit of residents in beds.</p>	<p>hospital care. Prior to occupancy days</p>
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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.