

Heritage Lifecare Limited - Annie Brydon Lifecare

Introduction

This report records the results of a Partial 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: Heritage Lifecare Limited

Premises audited: Annie Brydon Lifecare

Services audited: Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

Dates of audit: Start date: 6 May 2014 End date: 6 May 2014

Proposed changes to current services (if any): This partial provisional audit reviewed the use of 27 beds are being converted from rest home to dual purpose use.

Total beds occupied across all premises included in the audit on the first day of the audit: 66



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

Annie Brydon Lifecare provides rest home and hospital level care for up to 71 residents. The service is operated by Heritage Lifecare Limited and managed by a facility manager and a clinical services manager.

This partial provisional audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with management and staff. As limited time was spent on site the recent annual resident satisfaction survey results were also reviewed.

This audit has identified one area requiring improvement which relates to furniture in the facility. No areas requiring improvement were made at the provisional audit in October 2017.

Consumer rights

Not applicable to this audit.

Organisational management

Business and quality and risk management plans include the scope, direction and goals of the organisation. Monitoring of the services provided to the governing body is regular and effective. A suitably qualified person with experience in the sector 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. The February 2018 resident and family satisfaction survey was available during the audit and results of this survey are included in this report. 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. There is an understanding of the impact on staffing which the reconfiguration request will have and planning has commenced in response to this.

Continuum of service delivery

Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents' satisfaction with meals was confirmed in the annual satisfaction survey results. Current medicine management and food management systems are appropriate for additional dual use beds in the facility.

Safe and appropriate environment

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

Not applicable to this audit.

Infection prevention and control

The infection prevention and control programme, led by an experienced and trained infection control coordinator, aims to prevent and manage infections. The programme is reviewed annually.

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	15	0	1	0	0	0
Criteria	0	36	0	1	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 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Heritage Lifecare Limited (HLL) has a template business plan which is used in each facility and is reviewed annually. This outlines the purpose, values, scope, direction and goals of the organisation. The facility manager is developing the Annie Brydon business plan using the HLL template in conjunction with her regional operations manager. The draft plan was reviewed during the onsite audit and reflects the organisation's requirements. A sample of reports to HLL support office demonstrated that the facility manager is completing the necessary management reports and that these provide adequate information to monitor performance including occupancy, financial performance, emerging risks and issues. The clinical services manager is responsible for regular reporting of clinical issues and indicators.</p> <p>The service is managed by a facility manager who has held similar positions for the past 15 years. She has taken part in management training provided by previous employers and maintains her knowledge of the sector through attending conferences and internal training. Responsibilities and accountabilities are defined in a job description and she has an individual employment agreement. The facility manager confirmed knowledge of the sector, regulatory and reporting requirements. The facility manager is supported by the wider HLL group and an</p>

		<p>experienced clinical services manager who is a registered nurse (RN) who holds a current annual practising certificate. The clinical services manager maintains her clinical knowledge and management skills through professional development.</p> <p>The service holds contracts with the Taranaki District Health Board for the provision of rest home level care and hospital level care (geriatric and non-acute medical), long term chronic health conditions and short term respite care. They also hold contracts with the Taranaki Hospice for palliative care and with the Ministry of Health (MOH) for people under 65 with physical disabilities.</p> <p>Annie Brydon Lifecare is certified to provide care for up to 71 residents in a mix of rooms (44) and care suites (24) with a total of 68 across the facility. In the 24 care suites which residents live in under an occupation right agreement (ORA), at any time three of the suites are certified as double rooms so that couples can receive subsidised care.</p> <p>On the day of the audit, there were 66 residents. In the care suites 23 of the 24 care suites were occupied with one of the care suites occupied by a couple who were both receiving care. In the bedrooms, 43 of the 44 rooms were occupied.</p> <p>Of the 66 residents: 54 residents were receiving rest home level care and 12 were receiving hospital level care. One hospital level residents was an MOH funded resident who is under 65 years of age. There were no respite or palliative care residents on the day of the audit.</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>	<p>FA</p>	<p>In a temporary absence of the facility manager the clinical services manager carries out the delegated duties of the facility manager. She is supported by the HLL regional operations manager and a senior RN in the facility takes over the clinical services manager's role. There is an administrator who also provides back up and HLL support office staff members are available for assistance if needed.</p> <p>During absences of key clinical staff, the clinical management is overseen by a senior quality manager who is experienced in the sector and able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p>	<p>FA</p>	<p>The facility manager described essential notification reporting requirements, including for pressure injuries. They advised there have been no notifications of</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>significant events made to the Ministry of Health since the previous audit.</p> <p>Other staff members interviewed are aware of their responsibilities for reporting and recording adverse events, depending on their role. The topic is included in the annual training plan and meeting minutes included discussion of both individual events and summarised data.</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 HLL support office by the clinical services manager on a monthly basis.</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. Staff records reviewed showed documentation of completed orientation.</p> <p>Continuing education is planned on an annual basis and includes mandatory training requirements. 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. There are sufficient trained and competent registered nurses (four) who are maintaining their annual competency requirements to undertake interRAI assessments. Two more RNs are scheduled to attend training. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.</p> <p>The facility currently provides hospital level care. Appropriate topics are included in the annual training plan to support the provision of hospital care. Qualified nurses have their annual competencies assessed by the clinical services manager, as noted.</p>

<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>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 (24/7). This is based on the Indicators for Safe Aged Care and Dementia Care for Consumers handbook.</p> <p>The facility adjusts staffing levels to meet the changing needs of residents. 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. Observations and review of a four-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 and there is 24 hour/seven days a week RN coverage in the facility.</p> <p>All staff members interviewed stated that they were confident that staffing numbers would be increased as and when needed based on residents' needs. They stated that there has already been an increase in caregiver staff numbers since the provisional audit in October 2017. One group of 14 care suites are situated on an upper level. There is one staff member based upstairs to support these residents during the morning and afternoon shifts.</p> <p>Both the facility manager and clinical services manager were interviewed in relation to the rostering processes and staffing levels. Neither are responsible for another facility in addition to Annie Brydon Lifecare and both confirmed their confidence in the HLL staffing system and ability to make changes to staffing levels across the facility as residents needs change. A recent increase in care staff allocations was noted with the clinical services manager.</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.</p> <p>A safe system for medicine management was observed on the day of audit. The staff member (a RN) observed demonstrated good knowledge and had a clear understanding of their role and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage. The medication charts reviewed (nine) were those of all residents in the care suites who are receiving support with medication</p>

		<p>management. Similarly, the medication round was that undertaken for care suite residents.</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 monthly.</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>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices were noted and included the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines were met. The required three monthly GP review was consistently recorded on the medicine chart. Standing orders are used. These were current and comply with guidelines.</p> <p>On the day of this audit there were no residents who were self-administering medications. Appropriate processes are available to ensure this is managed in a safe manner, when self-administration is to be supported in the facility.</p> <p>There is an implemented process for the analysis of any medication errors through the clinical indicators system. Staff members interviewed discussed this and there was evidence of the process in the quality and risk meeting minutes reviewed during the audit.</p> <p>Annie Brydon already provides hospital level care to residents and there are appropriate systems to support medication management at this higher level of care. No changes are required to the facilities processes to be able to accommodate additional residents who may require hospital level care, as these exist. As noted, there are systems to increase staffing levels as and when needed.</p>
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management	FA	The food service is provided on site by cook and kitchen team and is in line with recognised nutritional guidelines for older people. The menu follows summer and

<p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>winter patterns and has been reviewed by a qualified dietitian in May 2017. Since the transition to HLL's ownership the cook has implemented new menus and has been able to make minor changes to meet the preferences of residents at Annie Brydon. She reported residents were initially unsure about the change in the menus but with their input she has developed a menu which meets the dietitian's requirements and the residents' preferences.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with a food control plan which has been submitted to the South Taranaki Council in early 2018. Food diaries were sighted and are being completed as required. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cooks and kitchen assistants have undertaken appropriate training for the roles.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The cook discussed the process by which personal food preferences, special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Evidence of this information was readily available and on display in the kitchen.</p> <p>Evidence of resident satisfaction with meals was verified in the satisfaction survey with a 4.1 out of 5 satisfaction result. The survey coincided with the initial introduction of the new menus. Menu changes and any other issues with the kitchen and food management are discussed in quality and risk meetings and recorded in the minutes. 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>As noted for Standard 1.3.12 HLL has appropriate procedures and guidelines to support residents who require hospital level care. These systems are implemented at Annie Brydon Lifecare. An increase in the number of residents at a higher acuity can be supported.</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</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. Staff members interviewed described the training they receive and the availability of information.</p>

<p>hazardous substances, generated during service delivery.</p>		<p>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 3 November 2018) is publicly displayed. The building is purpose built as an aged care facility. Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. Floor coverings are appropriate for residents who use mobility equipment and bathrooms, utility rooms and the kitchen have non-slip floor coverings. The environment was hazard free, residents were safe and independence was promoted.</p> <p>The facility is built with two wings connected by a group of rooms for residents receiving rest home level care. There are 10 care suites at ground level on one side and 14 on an upper level above larger rooms which are rooms for residents receiving hospital level care. This upper level has lift access to the ground floor. The lift has a current certificate of fitness which expires on 29 March 2019.</p> <p>Residents enter the care suites by purchasing an ORA. Residents who live in these suites may not require care on entry, but they may progress to requiring care over time. Currently all 24 care suites are certified for rest home level care should this be required. The care suites are made up of a large bedroom which can accommodate a couple in single beds or a double or queen size bed depending on their preference; a full-size bathroom; a small kitchenette with sink, small fridge and space for an electric kettle; and a living room. The size and orientation of the suites is suitable for the provision of hospital level care. The clinical services manager reported that the facility is able to adequately support residents in the care suites who currently require rest home level care. A change to the provision of hospital level care would be possible given the physical environment in the care suites.</p> <p>The testing and tagging of electrical equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed, interviews with staff and observation of the environment. External areas are safely maintained</p>

		and are appropriate to the resident groups and setting.
<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 are adequate numbers of accessible bathroom and toilet facilities throughout the facility. Residents in some rooms use shared bathrooms and toilets. All the care suites have their own full bathroom with shower, toilet and hand basin.</p> <p>Appropriately secured and approved handrails are provided in the toilets and shower areas, and other equipment and accessories are available to promote residents' 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/shared accommodation. Where rooms are shared approval has been sought. Rooms are personalised with furnishings, photos and other personal items displayed to each resident's preference.</p> <p>There is room to store mobility aids, wheel chairs and mobility scooters. Staff reported the adequacy of bedrooms.</p> <p>The clinical services manager described how they have supported residents in one care suite where palliative care was required. A bed was moved into the lounge and one remained in the bedroom so that the couple could remain together during the palliative phase and the family could visit them in their home in private.</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>	PA Low	<p>Communal areas are available for residents to engage in activities. There are dining and lounge areas on each side of the facility, known as Annie Brydon and Brydon Court. These are spacious and enable easy access for residents and staff. Residents can access smaller areas for privacy, if they choose.</p> <p>Furniture in dining rooms and the lounges is appropriate to the setting and residents' needs. However, the facility manager has made a recent changes to the furniture in communal areas with the introduction and layout of some new chairs in particular. An area for improvement is identified in relation to these chairs which have created a hazard for mobility, are not relaxing or comfortable</p>

		for residents to use, and are not designed for the resident group.
<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>Laundry is undertaken on site in a dedicated laundry. There are dedicated laundry staff members, although the person rostered on the day of audit was unavailable due to unanticipated leave. There are documented procedures for the management of laundry processes, including dirty/clean flow and handling of soiled linen. Additional staff were covering the laundry requirements in place of the laundry staff member.</p> <p>There is a small designated cleaning team who have received appropriate training. These staff are undertaking all internal training as confirmed in interview and through review of staff training records. Laundry staff members also attend internal training. Chemicals were stored in a lockable cupboard when not in use and were in appropriately labelled containers.</p> <p>Results from the resident satisfaction survey demonstrated that residents are satisfied with cleaning and laundry services. Domestic services rated 4.3 out of 5 and laundry services rated 4.1. The most recent internal audits of the laundry and cleaning services (completed in March 2018) confirm that all HLL processes are being followed and cleaning and laundry staff are performing their functions to the required organisational standard.</p> <p>Current cleaning and laundry services can already accommodate hospital level care. Designated staff members have access to appropriate guidelines and support from clinical staff if needed. Staff members in the cleaning team reported their confidence in the organisation providing additional time and staff resources if and when needed.</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>	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 17 July 2013, when the most recent structural changes were made to the facility.</p> <p>A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being in February (22 February 2018). The</p>

		<p>orientation programme includes fire and security training and regular training with the six monthly evacuation 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 maximum number of residents (71). Water storage tanks are located around the complex, and there is a generator on site. Emergency lighting is regularly tested.</p> <p>Call bells alert staff to residents requiring assistance. During the audit visit the call bells were responded to promptly. Call system audits are completed on a regular basis.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and a security company checks the premises 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>	<p>FA</p>	<p>All residents' rooms and communal areas are heated and ventilated appropriately. There is central heating throughout the facility and in residents' rooms.</p> <p>Rooms have natural light, opening external windows and external views.</p> <p>Areas were a comfortable temperature throughout the audit and the satisfaction survey results 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 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. The HLL infection control programme is reviewed annually and was current at the time of this audit. The IPC coordinator has access to the infection prevention and control nurse at the Taranaki DHB if this is needed.</p> <p>The clinical services manager is the designated IPC coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to HLL support office, and tabled at the quality and risk and RN / EN meeting. This committee includes the</p>

		<p>facility manager, IPC coordinator, all RNs and ENs and the quality manager who works one day a week at the facility. 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.</p> <p>No changes are required to the IPC programme and associated infection control manual to accommodate an increase in the number of hospital level residents.</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 1.4.5.1</p> <p>Adequate access is provided where appropriate to lounge, playroom, visitor, and dining facilities to meet the needs of consumers.</p>	PA Low	<p>In bedrooms residents have their own furniture and some utilise mobility equipment and a hospital bed if needed. In the communal areas there is still the furniture which is appropriate for the use of residents who have impaired mobility, an increased need for comfortable seating and furniture which is specifically designed for older adults who have care needs.</p> <p>A large number of hard plastic folding chairs have been purchased by the new facility manager and were in use in two of the three communal lounges. In quality meeting minutes the chairs have been purchased for celebrations and activities. On the day of the audit they were in use by residents as the only readily available seating to watch television and take part in activities.</p>	<p>At the time of the audit visit the facility manager had introduced new furniture into the communal areas of the facility which was not appropriate to an age care setting. Existing, more appropriate furniture had been rearranged to accommodate the new chairs. Residents meeting minutes indicated that they do not like the rearrangement of furniture or the new chairs. Residents have expressed their comments strongly in their meetings with the manager and advocate.</p> <p>During the onsite audit the new chairs were seen to be arranged in ways which compromised residents' comfort, and their ability to negotiate the lounges easily and independently. A lounge which had appropriate furniture had been rearranged and was not used at all by residents or</p>	<p>Ensure that appropriate furniture is made available to residents throughout the facility in communal areas, which is comfortable and arranged in ways which meet the needs and preferences of residents.</p> <p>30 days</p>

		<p>More suitable armchairs for the resident group had been rearranged by the facility manager in the third lounge. The facility manager stated that this was so that families can have private meetings. On the day of the audit this room was not used by either residents or families meeting with their relatives.</p> <p>Due to the addition of the new chairs the environment is now cluttered and does not look as inviting as it did at the last onsite audit in October 2017. Residents were not observed to be using all areas of the facility as they previously had.</p> <p>Comments in resident meeting minutes from February and March 2018 over the time that these changes have been made note that residents are not positive about the changes in the arrangement of the furniture and the introduction of the new chairs. The minutes reflected that, despite these comments, the manager has indicated that the trial will go ahead and be reviewed. At interview, the manager stated that she believed the changes were positive.</p> <p>Since the audit visit the National quality manager has reported that support office have ensured that furniture has been returned to previous arrangements.</p>	<p>family members on the day of the audit.</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.