

# Good Future Auckland Limited

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## Introduction

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

The audit has been conducted by HealthShare 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:** Good Future Auckland Limited

**Premises audited:** New Windsor Rest Home

**Services audited:** Rest home care (excluding dementia care)

**Dates of audit:** Start date: 13 January 2015      End date: 13 January 2015

**Proposed changes to current services (if any):** None

**Total beds occupied across all premises included in the audit on the first day of the audit:** 22

# Executive summary of the audit

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## 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

New Windsor Rest Home provided residential care for up to 27 residents who required rest home care. Occupancy on the day of the audit was 22. The rest home is owned and operated by Good Future Auckland Ltd. This unannounced surveillance audit was undertaken to confirm that the rest home continued to meet specified parts of the Health and Disability Services Standard and the District Health Board aged care contract.

There were no previous improvements identified at the last audit. Five improvements were identified during this audit. Improvements were required to the corrective action process, human resource process, maintenance requirements and the appropriate management of emergency exits.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Residents were of Chinese descent and communication processes were appropriate to their needs. This included the interpretation and translation of critical documents and information. Open disclosure procedures ensured that communication was maintained in

an open and transparent manner. Communication with residents and family about adverse events and other matters were documented. Families interviewed confirmed good communication between management, carers, families, and residents.

The complaints process complied with Right 10 of the Code. A complaints register was maintained. There were no complaints outstanding at the time of this audit. Complaints were used to improve the quality of service delivery.

## 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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The scope, direction and goals of the organisation were documented. A quality consultant conducted quarterly service reviews and benchmarking. The facility manager was responsible for the overall service delivery, business administration, quality systems and human resource management.

The strategic and business plan was current. The required policies and procedures were documented and controlled, however one policy required an amendment. An audit schedule was implemented and an adverse event reporting systems were planned and coordinated. An additional improvement is required to the corrective action process.

Human resource processes were appropriate, however not fully implemented with regard to staff training and performance reviews. There was a documented rationale for determining skill mix in order to provide safe service delivery. Staff were experienced in the aged care sector. A registered nurse was employed to cover the required hours.

## Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Care and support was provided by competent staff. Timeframes for service delivery were all met and included input from allied health professionals, residents and families. Nursing interventions were consistent with good practice and care plans well utilised. Activities were provided which were appropriate and met cultural needs. Family members interviewed confirmed residents were well supported to maintain interests. The service implemented a medication system; however, there is a requirement to define processes for medication reconciliation within policies and procedures. Residents' nutritional needs were met. Special needs were catered for and monitored. Food services and storage met food safety requirements.

## 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 medium or high risk and/or unattained and of low risk.</p>
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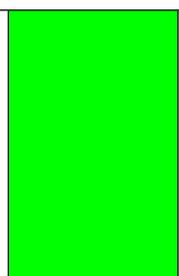
There had been one minor alteration to the layout of rooms since the last audit. This did not require an amendment to the fire evacuation plan or building warrant of fitness. The current building warrant of fitness was sighted. Improvements are required regarding on-going maintenance and emergency exits.

## 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 use of restraints and enablers was minimal. Policies and procedures provided accurate definitions on restraints and enablers. The use of enablers was voluntary and, if required, they were used safely.

## 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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An infection control surveillance programme was implemented. Infection rates were monitored with preventative actions documented and communicated to staff and residents. The numbers and types of infections were collated and benchmarked.

## 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)
<b>Standards</b>	0	12	0	2	2	1	0
<b>Criteria</b>	0	41	0	2	2	1	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>There were appropriate systems to manage complaints. Information on the complaints process was displayed. Complaints forms were easily accessible. A complaints register was maintained. Records of complaints included evidence that all complaints/concerns had been resolved to the satisfaction of the complainant. Remedial actions were implemented where required.</p> <p>In interviews, staff were aware of their responsibilities in relation to complaints. Staff advised that any concerns raised by residents and or family were addressed proactively. This was evident in records of residents meeting minutes.</p> <p>In interview, family members confirmed their understanding of the complaints process. All family members interviewed were satisfied with the care that was being provided.</p> <p>The manager reported that there had been no complaints to the health and disability commissioner or the district health board.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with</p>	FA	<p>All residents spoke Chinese or Cantonese. Written information was provided to residents in their own language. This included translation of their resident agreements, information on resident rights, complaints and satisfaction surveys. All staff, with the</p>

<p>consumers and provide an environment conducive to effective communication.</p>		<p>exception of the registered nurse, spoke Chinese or Cantonese. A number of family members spoke English and could also interpret for the residents if required. It was also reported that access to interpreter services was available through external services if required.</p> <p>The open disclosure policy identified that frank discussions with residents and their support person/family was required. There was evidence in records of adverse events, residents' files and resident meeting minutes that open communication was occurring. In interviews, family members confirmed they were kept informed of all relevant issues. Family contact sheets were maintained.</p> <p>Residents were able to identify staff involved in their care. Staff were identified by uniform and name badge.</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>	<p>FA</p>	<p>The organisation is owned by the two directors, one of which is onsite seven days per week. One of the directors was the manager, and the other was the activities coordinator. The directors were assisted by an external consultant who provided on-going support and education in aged care management. This included quarterly reviews of organisational performance.</p> <p>The manager had previous experience in managing rest homes in Auckland. The manager's position description clearly outlined the responsibilities and authorities of the role. The manager was also supported by the residential care coordinator. The residential care coordinator was previously a caregiver who had been appointed into a more senior role.</p> <p>The purpose, values, scope, proposed direction and the objectives were documented in the strategic and workforce goals. The values/goals/objectives/vision statement was displayed in the entrance to the facility.</p> <p>Both of the directors and the residential care coordinator were interviewed. This confirmed the individual roles and responsibilities throughout the organisation and that a senior staff member was onsite at all times.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented,</p>	<p>PA Low</p>	<p>A business, quality and risk management plan (2013-2015) was documented. The plan included quality goals and identified risks related to business management, clinical management, human resource management and emergency management. In interview, staff demonstrated an understanding of the quality and risk management</p>

<p>and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>system with regard to reporting adverse events and internal monitoring processes.</p> <p>The required policies and procedures were accessible to staff. All policies and procedures were developed by the external consultant and reviewed annually. Obsolete documents were removed from circulation. A reference list of all guidelines, standards and legislative requirements was available to guide the manager. Some policies and procedures had been translated into Chinese and Cantonese. Clinical policies were reviewed with input from the registered nurse. An improvement is required to the medication reconciliation policy to ensure best practice (refer standard # 1.3.12).</p> <p>The external consultant conducted quarterly service review meetings. Meeting minutes confirmed that key components of service delivery were linked to the quality management programme. This was inclusive of event reporting, complaints management, infection control, health and safety and restraint minimisation. Collated data on quality indicators was also shared at staff meetings. External benchmarking was conducted.</p> <p>Internal audits were implemented as per the annual schedule. The schedule included all components of the quality system. The process for implementing corrective actions was defined, however there was insufficient evidence that corrective actions had been completed, were successful or had been approved by management.</p> <p>Risks to the business were identified, with the exception of a current hazard register (refer standard # 1.4.2). There were documented emergency procedures for pandemics and civil defence emergencies. Clinical risks were documented in resident files. Business continuity insurance was in place and financial accounts were externally audited.</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>Adverse events were recorded and investigated. There was documented evidence that residents and family were kept informed. This was confirmed in interviews with family members.</p> <p>Records of adverse events were sampled. Related resident progress notes confirmed that the appropriate interventions were implemented. This included immediate actions and notifications. In interview, the general practitioner and registered nurse confirmed that in the event of injury, notifications were made in a timely manner.</p> <p>Reviewing and collating events was the responsibility of the register nurse. Events were logged on a register and analysed monthly. Trends were monitored. Remedial</p>

		<p>actions were communicated to staff where required. The rest home continued with a benchmarking programme for all adverse events. This provided a full analysis with other similar providers.</p> <p>In interview, management and staff confirmed their responsibilities when reporting events.</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>	PA Low	<p>The organisation employed 14 staff members. This was a combination of carers, auxiliary staff and administration/management staff. Staff files were sampled. The required job descriptions, employment agreements and recruitment records (including references and police checks) were in place.</p> <p>All new staff received an orientation. Induction work books were utilised. These included training on the essential components of service delivery and emergency procedures.</p> <p>A copy of the current practicing certificates was maintained. This included annual practicing certificates for the registered nurse, general practitioners (GP's) and a food safety certificate for the cook. All staff had a current first aid certificate.</p> <p>A planned programme of education was implemented; however the in-service education programme did not all requirements of the district health board contract. Personnel records sampled indicated that clinical competency requirements were maintained. This included medication competencies and conducting nursing interventions. In interview, staff confirmed access to sufficient training. This was also confirmed in interview with the registered nurse. The GP was satisfied that care was provided in a competent manner.</p> <p>All staff were required to have a performance appraisal annually. Current performance appraisals were not sighted.</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>	FA	<p>The documented staffing policies, review of the roster and interviews with family members indicated that suitable staffing was maintained. Staffing was adequate in both numbers and skill mix to meet the needs of residents over the 24 hours.</p> <p>There were sufficient numbers of carers rostered on each shift. A registered nurse was onsite one day per week and on call 24 hours a day. Each shift was covered by a staff member with a current first aid certificate.</p> <p>The manager was onsite five days per week. The manager had previous nursing</p>

		experience (in China) and had completed recent training in aged care. In addition, there was also a cleaner, laundry person and cook on site seven days per week.
<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>PA Moderate</p>	<p>There were accessible and documented policies and procedures for all stages of medicine management, including self-medicating. There were however, discrepancies identified in documents related to the reconciliation of medicines, and therefore, medicines were not reconciled when they were initially received by the facility.</p> <p>Interviews with staff, and observation of the lunch time medication round, confirmed that only staff who had been assessed as competent, were responsible for administering medications. Administration was observed to be safely maintained. Medication competency records were sighted.</p> <p>Medications were held in a locked drug trolley and locked cabinet, with the keys being held by the staff member who was responsible for medications on the day.</p> <p>Medication charts were sampled. All medicines had been prescribed by the GP using a pharmacy generated medication chart. All medication charts included photo identification and alerted staff to identified allergies. Three monthly GP reviews were evident. 'As required' medications had documented indications for use, and the RN verified accessibility to the pharmacy for advice as required. Only individually prescribed medications were used and a blister pack system utilised. At the time of the audit, there were no controlled drugs on the premises and no residents who self-administer medications.</p> <p>Accurate medication administration records were maintained, and a 'medication problem sheet' utilised, for example, when a resident refuses medication.</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>	<p>FA</p>	<p>Residents were provided with a well-balanced diet which met nutritional requirements. The menu had been reviewed by a dietician, and the report sighted confirmed an 'excellence' achieved. Staff interviewed confirmed there had been no changes made to the menu since it was reviewed. Families interviewed confirmed satisfaction with the meals provided. The cook was of Asian decent and confirmed that meals met cultural needs.</p> <p>Staff interviewed confirmed dietary assessments were completed on admission and these were sighted in files sampled. Documents sighted in the kitchen confirmed special dietary requirements were identified and 'likes' and 'dislikes' information</p>

		<p>obtained. A record of individual resident intake was recorded in resident files on a daily basis. Residents were observed during lunch time meal and appeared happy. Portions provided were sufficient with little wastage.</p> <p>Residents with special dietary requirements were catered for, and there was documentation sighted which recorded any special requirements. One resident for example, required a salt reduced diet, and this was provided. Staff interviewed confirmed this information was passed onto the cook, and documents written by the GP confirmed an improvement in the health status of the resident.</p> <p>Kitchen staff had required food safety qualifications. The kitchen and pantry were sighted. The kitchen was well stocked, clean and tidy. Fresh fruit and vegetables and other food stuffs were stored appropriately. Documentation of temperature monitoring and cleaning schedules were maintained. Food in the fridge was covered and dated as necessary. There had been no reported incidents of residents becoming unwell as a result of poor food handling practices.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>The RN, GP and care staff were interviewed regarding prescribed care for residents. Care plans sighted had documented goals and related interventions were consistent with best practice. Short term care plans had been developed as required. Care staff confirmed that they used care plans as a guide for providing care. Documentation completed by care staff, confirmed their understanding of interventions required to ensure residents needs are managed.</p> <p>Specific care plans sampled, confirmed the involvement of allied health staff as required. For example, behavioural management issues had been identified, and input from specialist services provided. The GP expressed a high level of satisfaction with the service and had confidence that interventions were implemented in an appropriate and timely manner.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The activities co-ordinator was interviewed. The activities co-ordinator facilitated activities five days per week, and also ensured the daily exercise programme was maintained during weekends. A record of activities was maintained on individual resident files and confirmed the provision of sufficient internal and external activities. Cultural needs were addressed with input sought from a local community centre.</p> <p>Documentation reviewed and families interviewed, confirmed participation was</p>

		voluntary. Family members expressed a high level of satisfaction with activities provided. Residents were observed to be participating in, and enjoying Mah-jong and Tai chi which is a daily occurrence.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Files sampled included comprehensive and timely evaluations. Goals were documented and reviews included the level of achievement towards meeting those goals. The registered nurse (RN) confirmed evaluation of service delivery was ongoing and included clinical staff and families. Documentation sighted verified evaluations were completed three monthly, and care plans evaluated and updated at least six monthly as required. The RN initiated changes to the plan of care where progress was different from expected, for example acute care plans. Interview with family members and the GP confirmed a high level of satisfaction with support provided by service staff to help residents achieve their desired outcomes.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	PA Moderate	There had been a minor alteration to the building since the last audit. The medication room had been changed into two separate toilets. This did not change the external exterior and did not require a change in the building warrant of fitness (BWOFF). The current BWOFF expires in May 2015.  Maintenance services were provided by a contractor, on an 'as required' basis. A number of maintenance and environmental hazards were sighted during the audit and further improvements were required.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	PA High	All staff received training on the management of emergencies. Appropriate equipment was provided, including bulk supplies in the event of a civil defence emergency. The fire evacuation scheme was approved by the fire department in 2013. Trial evacuations were conducted six monthly. Records of attendance were maintained.  The building had a sprinkler system and smoke alarms. Areas were separated by smoke stop doors. Emergency exits were identified, however one of the emergency exit doors was tied up with rope and an immediate improvement was required. This was resolved on the day of the audit.  Alternative arrangements were in place in the event of emergencies. There was a call system throughout the building.

<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>An infection control surveillance programme was documented and implemented. All infection reports were viewed by the registered nurse. These were collated and analysed for trends. Infections were reported at monthly staff meetings. Meeting minutes included discussions on events and preventative actions. The manager completed external benchmarking on infections. Benchmarked reports sampled confirmed that the infection control programme was effective in monitoring and preventing infections.</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 included an accurate description of restraints and enablers. This included the voluntary use of enablers. One resident was using a bed rail as an enabler (refer criterion # 1.3.3.3). The use of a bed rail, as an enabler, had been approved. The required documents and consents were sighted.</p> <p>In interview, staff demonstrated an understanding of enablers, however annual training had not been conducted, as required. An improvement has been documented in criterion # 1.2.7.5.</p>

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	PA Low	<p>Internal audits were sampled and checked against the schedule. These were conducted by the manager, residential care coordinator and the registered nurse. Audits sampled were well documented and identified where a service short fall had occurred. Corrective actions were written. In interview, the manager and residential care coordinator reported that corrective actions were then implemented, however there was no documented evidence that this had occurred, or that corrective actions were successful in resolving the problem. A number of audits were also not signed off by management.</p>	<p>Insufficient evidence that (a) corrective actions had been implemented, (b) had been successful in resolving service shortfalls or (c) were signed off by management, as required.</p>	<p>Maintain evidence that corrective actions are implemented, successful and signed off by management, as required.</p> <p>90 days</p>
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate,</p>	PA Low	<p>All staff were required to have an annual performance appraisal. These were</p>	<p>(a) Performance appraisals had not been conducted</p>	<p>(a) Complete staff performance appraisals</p>

and record ongoing education for service providers to provide safe and effective services to consumers.		<p>conducted by the manager. Performance appraisals were due in August 2014. A current performance appraisal was not sighted in four out of seven staff files sampled.</p> <p>The education programme included mandatory training requirements; however training on restraints and enablers was not included on the annual plan.</p>	<p>annually (b) Annual training did not include restraints and enablers.</p>	<p>annually (b) Conduct annual training on restraints and enablers.</p> <p>180 days</p>
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>PA Moderate</p>	<p>There was no evidence that medicines were reconciled when initially received by the facility.</p>	<p>The requirements for medication reconciliation had not been consistently defined within policies and procedures.</p>	<p>Define and document a consistent process for medication reconciliation that includes authorities, responsibilities and recording requirements.</p> <p>60 days</p>
<p>Criterion 1.4.2.4</p> <p>The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.</p>	<p>PA Moderate</p>	<p>A maintenance book was on site. Maintenance requirements observed by staff were required to be added to the book. An external contractor then addressed these issues as required. Maintenance requests included the identification of a hazard (if applicable) and were signed off once corrected, however a hazard register, which included all hazards throughout the facility, had not been documented. In addition, number of environmental hazards and areas requiring minor maintenance were sighted during the audit. These had not been added to the maintenance schedule.</p>	<p>(a) Not all maintenance requirements had been identified or fixed (b) A hazard register was not sighted.</p>	<p>(a) Repair areas identified as requiring maintenance (b) Document a hazard register.</p> <p>30 days</p>

<p>Criterion 1.4.7.1</p> <p>Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.</p>	<p>PA High</p>	<p>In interview, staff reported that a resident had used the rope to secure the emergency exit. This was removed immediately. All other emergency exits were unobstructed.</p>	<p>One emergency exit was tied shut with rope.</p>	<p>Provide evidence that staff and residents have received information regarding the management of emergency exits.</p> <p>7 days</p>

## Specific results for criterion where a continuous improvement has been recorded

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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
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End of the report.