

The Rest Homes Limited - Makoha Rest Home

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:	The Rest Homes Limited
Premises audited:	Makoha Rest Home
Services audited:	Residential disability services - Intellectual; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical; Residential disability services – Sensory
Dates of audit:	Start date: 1 October 2019 End date: 1 October 2019
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:	28



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
Yellow	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
Red	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

Makoha Rest Home provides residential services for up to 34 residents. This includes the provision of rest home level care, hospital level care and respite rehabilitation services. There have been some changes to the organisation since the last audit. The management structure has changed, there have been some minor alterations to the building and an electronic medication management system has been implemented.

This unannounced surveillance audit was conducted against a sub set of the Health and Disability Service Standards and the providers contract with the district health board (DHB). The audit included a review of quality related records, samples of both resident and staff files, observations and interviews with residents, family members, staff and management. A general practitioner was not available for interview during the audit. Resident files sampled included those accessing all services provided. The audit also followed up on previously identified areas requiring improvement identified at the last recertification audit, which have all been sufficiently addressed.

There were three additional areas of improvement identified during this audit. These related to the change in management structure, the management of controlled drugs and a food control plan.

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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Open communication between staff, residents and families is promoted, and was 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. Resident records are maintained as required. The complaints process meets consumer rights legislation.

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 owners/directors monitor organisation performance and review the strategic direction of the organisation. Day to day operations are shared by the office manager and clinical nurse manager. The quality and risk management programme is implemented and quality related data is collated and analysed. Corrective actions are developed and implemented as required. Adverse events are well managed.

There are a sufficiently qualified number of staff on duty at all times. All staff receive an orientation and are provided with ongoing education opportunities. Staff performance is monitored.

Residents' records are maintained as required.

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.		Some standards applicable to this service partially attained and of low risk.
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Residents are assessed prior to entry to the service to confirm their level of care. The process for assessment, planning, evaluation and exit are provided by suitably qualified staff. InterRAI assessments and individualised care plans are documented.

The service provides planned activities that meet the needs and interests of the residents as individuals and in group settings. There is a medicine management system in place. Three monthly medication reviews are conducted by the general practitioners (GPs).

The food service provides and caters for residents. Specific dietary likes and dislikes are accommodated. Residents' nutritional requirements are met.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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There have been minor changes the facility. These did not require a change in the approved evacuation plan. There is a current building warrant of fitness.

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. Two restraints and one enabler were in use at the time of the audit. A comprehensive assessment, approval and monitoring process with regular reviews occurs. The use of enablers is voluntary for the safety of residents in response to individual requests. In service staff education on restraints, enablers and the management of challenging behaviour is provided.

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 infection prevention and control surveillance programme is appropriate to the size and scope of the service. The required data is collected, analysed and communicated.

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	3	0	0	0
Criteria	0	44	0	3	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
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	<p>The complaints process aligns with consumer rights legislation. There has been one formal resident complaint since the last audit. Records sampled confirmed a comprehensive investigation was conducted within the required timeframes. The complaint was resolved to the satisfaction of the complainant and family/whanau. Information and advice were provided regarding external advocacy services and the Health and Disability Commission. The complaints register includes all complaints, dates and actions taken. Complaints are linked to the quality and risk management system and discussed at staff and management meetings. The clinical nurse manager reported that there have been no complaints made to external authorities since the last audit.</p> <p>Residents and family interviewed confirmed they have had the complaints procedure explained to them and they understood their right to make a complaint. Day to day concerns are often discussed at resident meetings and addressed in an ongoing manner. The organisation also collates compliments from residents, family/whanau and visitors. All compliments are shared with staff.</p>
Standard 1.1.9: Communication Service providers communicate effectively	FA	<p>Records of adverse events confirmed that open disclosure is practiced in the event that an error has occurred. For example, an error in medication administration. The open disclosure process includes an apology from the organisation. There was also evidence that family/whanau, or representative, are contacted following events or changes. Family contact is recorded in residents' records. Interviews with residents and family members</p>

<p>with consumers and provide an environment conducive to effective communication.</p>		<p>confirmed that they are kept informed.</p> <p>Interpreting services are available from the district health board (DHB). There were no residents requiring the use of interpreting services during the time of the audit. A number of residents and staff speak Te Reo.</p> <p>The admission agreement and service information are available in large print. Residents sign this agreement on entry to the service. The agreement provides clear information regarding what is paid for by the service and by the resident and meets DHB requirements.</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>PA Low</p>	<p>The organisation is governed by two owner/directors. Both are registered medical practitioners. One of the directors is a frequent visitor to the site and provides leadership and some staff training. The strategic direction of the organisation has been revised to include rehabilitation services for people with an acquired brain injury. Rehabilitation services include residential respite, physiotherapy and speech language therapy. The mission statement is displayed on entry to the facility. There is a business risk assessment and management plan which contains the purpose, values, scope, and direction.</p> <p>The previous facility manager and clinical nurse manager are no longer with the service. Day to day operations are now the responsibility of the office manager and the clinical nurse manager (CNM) both of whom were employed in May 2018 and are both on site during business hours Monday to Friday. These roles have been combined and replace the previous role of the facility manager. These roles continue to be defined and there is evidence of ongoing discussions regarding the responsibilities, authorities and accountabilities of the management team. The DHB is aware of the changes in the management structure. The Ministry of Health (MOH) was notified on the day of the audit.</p> <p>Organisational performance is monitored by the management team. The management team includes one of the directors, the office manager, the CNM and an external consultant who has been with the organisation since the rest home was purchased. The external consultant has provided continuity to the organisation during the changes in management structure. Records of management meetings sampled confirmed discussions regarding issues/risk, organisational performance, complaints, residents, staffing and health and safety. The CNM also provides the directors with fortnightly reports including outputs, staffing, risk, equipment/maintenance and the office manager maintains all financial records.</p> <p>The clinical nurse manager has had over 20 years' experience in aged care service, is a registered nurse and graduated in 2006. The CNM has also had experience managing a high dependency unit. The CNM has recently commenced career force assessor training, is trained in the use of interRAI and attends regional aged residential care meetings. The administration manager provides support with administration; oversight of contracts and human resources. The office manager's position description has recently been amended to better reflect a management position. Management responsibility, authorities and accountabilities are documented in the CNM position description.</p>

		<p>Makoha Rest Home and Hospital provides residential disability services, rest home and hospital level care for up to 34 residents. On the day of audit there were 28 residents. This included eight residents requiring hospital level care and 18 residents requiring rest home level care under the aged residential care contract. There were two respite residents who were funded through the Accident Compensation Corporation (ACC) and two boarders. Approval for the reconfiguration beds to accommodate rehabilitation services was made by Ministry of Health in September 2018. There were 10 residents under the age of 65 years.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>The documented quality and risk management system is now fully implemented. Policies and procedures are purchased by an external consultant and remain current. There is a document control system which ensures documents are approved, up to date and managed to preclude the use of obsolete documents. Policies and procedures are available to staff in hard copy and introduced to new staff during the orientation process</p> <p>A range of quality related data is collected, collated and used to identify necessary improvements. The external consultant conducts annual resident and staff satisfaction surveys and shares the results of these with management, including any opportunities for improvement. Information regarding complaints, adverse events, health and safety, restraint use, internal audits and infection prevention and control are discussed in full at staff meetings. There are also monthly RN meetings. These meeting include clinical discussions and a review of clinical indicators. Resident meetings have commenced since the last audit. These include discussions regarding the environment, meals and activities. There is evidence that feedback is considered and changes made as possible. These meetings are chaired by the diversional therapist (DT).</p> <p>There is an internal audit schedule, the responsibility of which has been delegated to the unit coordinator. This is a new role within the organisation and includes eight hours per week for auditing and collating all quality related data. The unit coordinator is a registered nurse. The internal audit system reviews practices and the key components of service delivery. Corrective action plans are developed from identified areas of improvement and there is now sufficient evidence that corrective actions are being addressed and closed out in a timely manner. This addresses the previously identified area of improvement.</p> <p>Actual and potential risks are identified, documented and appropriately communicated. The risk and hazard register includes the identified risks, how these are monitored, if the risk is significant and if the implemented actions can isolate, eliminate or minimise the risk. There is evidence that any risks or concerns are reported to the director and discussed during management team meetings. This includes newly identified risks associated in the provision of rehabilitation services which is being addressed by the owner/director through the provision of additional staff training.</p>
Standard 1.2.4: Adverse	FA	<p>The adverse event reporting system has not changed since the last audit. Adverse events sampled confirmed that events are reported, recorded and reviewed. A monthly record of events is collated by the unit coordinator</p>

<p>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>and discussed at staff meetings. This includes an analysis and remedial actions. There was evidence that the resident and family members were included in the investigation process and notified as required.</p> <p>The clinical nurse manager gave two examples of essential notifications to the MOH which have occurred since the last audit. This included one unexpected death and one unstageable wound. In both events the required family notifications were made.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Human resource processes have not changed since the last audit; however, the responsibilities have. All human resource activities are now the shared responsibility of the management team. Staff files sampled confirmed that each employee has an employment agreement, evidence of criminal vetting and proof of qualification. All registered nurses have a current practicing certificate and a number of health care assistants have levels two to four of the health and wellbeing certificate. Staff performance is monitored. Performance appraisals are completed on an annual basis.</p> <p>There is a documented orientation and competency programme. The orientation programme includes the essential components of service delivery. Staff files sampled confirmed completion of orientation and evidence of medication, interRAI and first aid competencies for the registered nurses. Six RN's (including the CNM) are interRAI trained. Ongoing mandatory education is also provided for all staff. A review of records confirmed that the education provided meets requirements of the DHB contract. The owner/director has also provided additional staff education on working with people who have an acquired brain injury. The CNM has developed a wide range of learning resources (a resource library) which can be used as an ongoing training resource. The content of each training session is included.</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 staff rationale has not changed since the last audit. There is at least one registered nurse, with a current first aid certificate, on duty at all times. The number of health care assistants on each shift is determined by the needs of the residents. For example, there are four health care assistants rostered on the morning shift, three in the afternoon shift and one on the night shift. These numbers are adjusted as required with additional staff members rostered during busy periods, or a change in residents' needs. Cleaning, laundry, kitchen and activities staff are additional to the roster. On call duties are shared by the registered nurses, with the CNM being available at all times. The owner/director is also readily available. A review of the rosters confirmed that staff are replaced when absent. Residents, family members and staff interviewed expressed no concerns regarding the availability of staff.</p>

<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>Accurate resident records are securely maintained. Clinical notes were current and integrated with GPs and allied health service provider notes. Written records were legible with the name and designation of the person making the entry identifiable. The previous area requiring improvement relating to legibility, documenting of date of entry, designation, name and signature in all entries has been addressed.</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>PA Low</p>	<p>An electronic medication management system has been implemented since the last audit. This was in response to medication errors, none of which have occurred since the electronic system was installed. Indications for use are noted on 'as required' medications, allergies are clearly indicated, and resident photos are current. Administration records are maintained. The registered nurse was observed administering medications safely and correctly. All RN's who administer medications have current medication administration competencies and additional training has been provided by the medication system provider.</p> <p>The medication records and associated documentation are in place. Medication reconciliation is conducted by the registered nurses when a resident is transferred back to service. The RNs check medicines against the prescription. There was one resident self-administering medications, competency forms were completed and sighted in the residents files. Self-administration medication policy and procedure is in place. Outcomes of as required medicines were documented.</p> <p>An improvement is required reading the management of controlled drugs.</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>PA Low</p>	<p>The residents have a diet profile developed on admission which identifies dietary requirements, likes and dislikes and is communicated to the kitchen including any recent changes made. Diets are modified as required and the cook confirmed awareness of dietary needs required by the residents. Meals are served warm in sizeable portions and any alternatives are offered as required. The residents' weights are monitored monthly and supplements are provided to residents with identified weight loss issues. Snacks and drinks are available for residents when required. The family members and residents interviewed acknowledged satisfaction with the food service.</p> <p>All food services staff have completed training in food safety/hygiene. The kitchen and pantry were clean, tidy and well stocked. Labels and dates were on all containers and records of food temperature monitoring, fridges and freezers temperatures are maintained. Regular cleaning is conducted. An improvement is required regarding</p>

		a food control plan.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>The assessment findings in consultation with the resident and/or family/whanau, informs the care plan and assists in identifying the required support to meet residents' goals and desired outcomes. The care plans sampled were resident focused and individualised. Short term care plans were used for short-term needs. The behaviour management plans specify prevention-based strategies for minimising episodes of challenging behaviours and describe how the residents' behaviour is managed. Family/whanau interviewed confirmed they were involved in the care planning process. Resident files demonstrated service integration and evidence of allied healthcare professionals involved in the care of the resident such as the mental health services for older people, physiotherapists, occupational therapists, district nurses, dietitian and GPs.</p> <p>The previous area of improvement relating to insufficient documentation of strategies and/or interventions in the care plan to support achievement of desired outcomes has been addressed.</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>	FA	<p>All care plans sampled evidenced that interventions are adequate to address the identified needs in the care plans. Significant changes are reported in a timely manner and prescribed orders carried out. The RN reported that the GPs' medical input is sought in a timely manner, that medical orders are followed, and care is person centred. Care staff confirmed that care is provided as outlined in the care plan. A range of equipment and resources are available, suited to the level of care provided and in accordance with the residents' needs.</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>	FA	<p>The planned activities are appropriate to the residents' needs and abilities. The activities are based on assessment and reflect the residents' social, cultural, spiritual, physical, cognitive needs/abilities, past hobbies, interests and enjoyments. A residents' social history and assessment is completed within two weeks of admission in consultation with the family and residents where able. The activities are conducted by a diversional therapist assistant with oversight from an experienced qualified diversional therapist (DT).</p> <p>Activities are provided in individual or group settings. Activities are varied and appropriate for residents in the rest home, hospital wing, residents under 65 years and residents under the ACC contract have specific individual activities developed with goals that are rehabilitation focussed.</p> <p>Residents' files have a documented activity plan that reflects their preferred activities of choice and are evaluated every six months or as necessary. The residents were observed to be participating in a variety of activities during the audit. The planned activities and community connections are suitable for the residents. There are regular</p>

		outings/drives, for all residents (as appropriate). Residents and family members interviewed reported overall satisfaction with the level and variety of activities provided.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Resident care is documented on each shift by care staff in the progress notes. The registered nurses complete progress notes daily and as necessary. All noted changes by the care staff are reported to the RNs in a timely manner. Formal care plan evaluations, following interRAI reassessments to measure the degree of a resident's response in relation to desired outcomes and goals occur every six months or as residents' needs change. These are carried out by the RNs in conjunction with family, GPs and specialist service providers. Where progress is different from expected, the service is seen to respond by initiating changes to the service delivery plan. Short term care plans are reviewed weekly or as indicated by the degree of risk noted during the assessment process. Interviews verified residents and family/whanau are included and informed of all changes.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The building warrant of fitness expires in May 2020. There have been no changes in the building since the previous audit, other than minor alterations to two of the outdoor verandas. These changes did not require a building permit and did not result in any changes to the approved fire evacuation plan. One of the verandas was extended, with an additional barrier wall built to protect residents from tobacco smoke. This addresses the previously identified area of improvement. The other veranda has been closed in to make an additional storage area. There remain two large verandas for the residents to enjoy outdoor areas. All rooms are of sufficient size to accommodate residents and their activities. Equipment has been tested and tagged within the last year and all medical equipment has recently been calibrated. The service has a planned and reactionary maintenance programme. There is a current hazard register.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection	FA	The infection prevention and control programme has not changed since the last audit. Clear definitions of surveillance and types of infections (for example; facility-acquired infections) are documented. Infection summary logs are maintained. Surveillance data is gathered and collated by the unit coordinator and reported at monthly staff meetings. Surveillance records for the past three months were sampled. These included an in-depth analysis including comparisons, possible reason for increase/decrease and actions/recommendations.

control programme.		
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<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 coordinator provides support and oversight for enabler and restraint management in the facility. Restraint, enablers and the management of challenging behaviour is part of orientation and ongoing education is provided annually or as necessary. Staff meeting minutes evidenced that updates on restraint /enabler use and statistics is provided.</p> <p>A restraint register was in place. On the day of the audit, two residents were using restraints and one resident using an enabler, which were least restrictive and used voluntarily at their request. Approved restraints and enablers include bed rails and safety belts. The assessment, approval, monitoring and review process is the same for both restraints and enablers.</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 1.2.1.1</p> <p>The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.</p>	PA Low	The business risk assessment and management plan (2017) is fully documented and there is evidence that the purpose, values, scope, and direction of the organisation has been reconsidered with the introduction of services for people requiring rehabilitation services. The business plan also includes the quality plan, business objectives and who is responsible however, the plan has not been updated to reflect the current management structure.	The 2017 Business Risk Assessment and Management Plan requires updating to reflect the changes in management structure.	Update the 2017 Business Risk Assessment and Management Plan to reflect the changes in management structure.

				90 days
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	PA Low	<p>Residents receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. The service uses a pre-packed medication system. Medication is safely stored in locked cupboards and drug trolley. There were no expired medications on site. Records of medication fridge temperature monitoring were sighted. All medicines are reviewed every three months for rest home residents and monthly for hospital residents unless they are stable and the GPs deems that three monthly is sufficient. The controlled drug register is current and correct. Weekly stock takes are conducted, however six-monthly controlled drugs stock take was not being completed as required.</p>	<p>Six monthly controlled drug checks have not been completed as required.</p>	<p>Complete controlled drug checks as required.</p> <p>90 days</p>
<p>Criterion 1.3.13.1</p> <p>Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.</p>	PA Low	<p>The menu complies with recognised nutritional good menu planning practices appropriate for older people and those under the ACC contract preferred options are offered. There is a summer and winter four-week rotated menu pattern. The menu was reviewed by a registered dietitian however, the food service is still to be registered under the new food control plan.</p>	<p>There is no food control plan.</p>	<p>Obtain a food control plan.</p> <p>180 days</p>

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.