

# CHT Healthcare Trust - Hillcrest Hospital

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## Introduction

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

The audit has been conducted by Health and Disability Auditing New Zealand 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:

<b>Legal entity:</b>	CHT Healthcare Trust
<b>Premises audited:</b>	Hillcrest Hospital
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Dementia care
<b>Dates of audit:</b>	Start date: 5 October 2015 End date: 6 October 2015
<b>Proposed changes to current services (if any):</b>	This audit has assessed 60 previously hospital level care only rooms as appropriate to be used for either rest home or hospital level care.
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	69



# 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
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

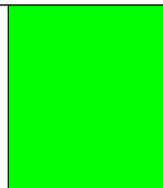
Hillcrest Hospital is owned and operated by the CHT Healthcare Trust and cares for up to 80 residents requiring hospital, dementia or residential disability (physical) level care. On the day of the audit, there were 69 residents. This audit has assessed that the service is able to use any of the 60 current hospital level beds to provide rest home or hospital level care. A unit manager, who is well qualified and experienced for the role and is supported by a clinical coordinator and the area manager, is overseeing the service. Residents, relatives and the GP interviewed spoke positively about the service provided.

This certification audit was conducted against the relevant Health and Disability standards and the contract with the district health board. The audit process included a review of policies and procedures; the review of residents and staff files, observations and interviews with residents, relatives, staff and management.

This audit has identified areas for improvement around wound documentation, pressure area management, activities and medication documentation. The service has exceeded the required standard around implementation of the pillars of care and the service provided to residents at risk of weight loss.

## 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.

Care is provided in a way that ensures residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner's Code of Consumers' Rights. Cultural needs of residents are met. Policies are implemented to support residents' rights, communication and complaints management. Family are involved in the initial care planning and provided with ongoing feedback. Regular contact is maintained with family including monthly registered nurse (RN) phone calls and if an incident/accident or a change in resident's health status occurs. Information on informed consent is included in the admission agreement and discussed with residents and relatives. The service has documented complaints and there is evidence of follow up. The complaints register reviewed, included verbal and written complaints and all sighted complaints are well managed.

## 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.



All standards applicable to this service fully attained with some standards exceeded.

Hillcrest has a current business plan and a quality assurance and risk management programme that outlines objectives for the next year. The quality process being implemented includes regularly reviewed policies, an internal audit programme and a health and safety programme that includes hazard management.

Aspects of quality information are reported to three monthly combined staff and quality meetings. Residents and relatives are provided with the opportunity to feedback on service delivery issues at monthly resident meetings and via satisfaction surveys. There is a reporting process being used to record and manage resident incidents. Incidents are collated monthly and reported to facility meetings. Hillcrest has job descriptions for all positions that include the role and responsibilities of the position. There is an annual in-service training programme and staff are supported to undertake external training. The service has a documented rationale for determining staffing and health care assistants, residents and family members report staffing levels are sufficient to meet resident needs.

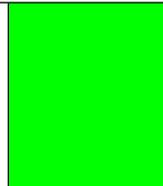
## Continuum of service delivery

<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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Primarily the registered nurses or clinical coordinator manages entry to the service. There is comprehensive service information available. A registered nurse completes initial assessments. Care plans and evaluations are completed within the required timeframe, by the registered nurses. Care plans are written in a way that enables all staff to clearly follow their instructions. Residents and family interviewed confirmed they were involved in the care planning and review process. The documented activities programme is varied and interesting. Medication is stored appropriately in line with legislation and guidelines. Staff have had education around medication management and all staff who administer medications have completed a competency assessment. General practitioners review residents at least three monthly or more frequently if needed. Meals are prepared on site. The menu is varied and appropriate. Individual and special dietary needs are catered for. Alternative options are able to be provided.

## 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.

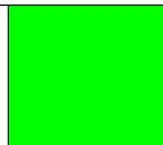


Standards applicable to this service fully attained.

The building has a current warrant of fitness and emergency evacuation plan. Ongoing maintenance issues are addressed. Chemicals are stored safely throughout the facility. All bedrooms are single occupancy and all hospital rooms have their own ensuite. The 60 rooms currently used for hospital residents are suitable to provide rest home level care. There is sufficient space to allow the movement of residents around the facility using mobility aids. There are a number of small lounge and dining areas throughout the facility in addition to its main communal area. The internal areas are able to be ventilated and heated. The outdoor areas are safe and easily accessible. Cleaning contractors and maintenance staff are providing appropriate services. Staff have planned and implemented strategies for emergency management. Emergency systems are in place in the event of a fire or external disaster.

## 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.

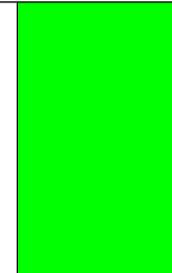


Standards applicable to this service fully attained.

A restraint policy includes comprehensive restraint procedures. A documented definition of restraint and enablers aligns with the definition in the standards. There is a restraint register and a register for enablers. There are currently six residents requiring restraints and six residents using enablers. Staff are trained in restraint minimisation and challenging behaviour management.

## 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.

Infection-control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel, in a timely manner.

## 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>	2	45	0	2	1	0	0
<b>Criteria</b>	2	96	0	2	1	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)
<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 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) policy and procedure is implemented. Discussions with staff (seven health care assistants (HCA's), three registered nurses (RN), one clinical coordinator, one area manager and one unit manager) confirm their familiarity with the Code. Interviews with ten residents from the hospital including three younger persons with disabilities (YPD) and six relatives (one from the dementia unit and five hospital) confirm the services being provided are in line with the Code. The Code is discussed at resident and staff/quality meetings.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed</p>	FA	<p>Informed consent processes are discussed with residents and families on admission. The resident or their EPOA signs written consents. Advanced directives are signed for separately. There is evidence of discussion with family when the GP completed a clinically indicated not for resuscitation order. Health care assistants and registered nurses interviewed confirmed verbal consent is obtained when delivering care. Discussion with family members identified that the service actively involves them in decisions that affect their relative's lives.</p> <p>Nine of nine resident files sampled (three from the dementia unit and six from the hospital) have a signed admission agreement and consents.</p>

consent.		
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>A policy describes access to advocacy services. Staff receive training on advocacy. Information about accessing advocacy services information is available in the entrance foyer. This includes advocacy contact details. The information pack provided to residents at the time of entry to the service provides residents and family/whānau with advocacy information. Advocate support is available if requested. Residential disability residents have a contact person documented in their file who can be contacted if advocacy is required (as do all other residents). Interview with staff, residents and relatives informed they are aware of advocacy and how to access an advocate.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents are encouraged to be involved in community activities and maintain family and friends networks. On interview, all staff stated that residents are encouraged to build and maintain relationships. On interview, all residents and relatives confirmed this and that visiting could occur at any time.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service has a complaints policy that describes the management of the complaints process. There is a complaints form available. Information about the complaints process is provided on admission. Interviews with residents demonstrated an understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints.</p> <p>There is a complaints register. Complaints for 2015 to date were reviewed. Verbal and written complaints are documented. There have been nine complaints in 2015 to date. All complaints have noted investigation, time lines, corrective actions when required and resolutions. Results are fed back to complainants. There has been a complaint via the Health and Disability Commission and the DHB. The DHB remedial actions from the complaint have been reviewed at this audit and remain embedded in practice. The HDC complaint into the same circumstance remains open. Discussions with residents and relatives confirmed that any issues are addressed and they feel comfortable to bring up any concerns.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p>	FA	<p>There are posters of the Code on display throughout the facility and leaflets are available in the foyer. The service is able to provide information in different languages and/or in large print if requested. Information is also given to next of kin or EPOA to read with the resident and discuss. On entry to the service an RN, the</p>

Consumers are informed of their rights.		clinical coordinator or the manager discusses the information pack with the resident and the family/whānau.
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>The service has policies, which align with the requirements of the Privacy Act and Health Information Privacy Code. Staff were observed respecting resident's privacy and could describe how they manage maintaining privacy and respect of personal property. All residents interviewed stated their needs were met.</p> <p>There is a policy that describes spiritual care. Church services are conducted in the facility every week. All residents and relatives interviewed indicated that resident's spiritual needs are being met when required.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>The service has established cultural policies to help meet the cultural needs of its residents. There is a Māori health plan. Staff training includes cultural safety. The service is able to access Māori advisors as identified in the Māori health plan and policies.</p> <p>Cultural and spiritual practice is supported and identified needs are incorporated into the care planning process and review. Discussions with staff confirm that they are aware of the need to respond to cultural differences.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The service has established cultural policies aimed at helping to meet the cultural needs of its residents. All residents and relatives interviewed reported that they were satisfied that their cultural and individual values were being met.</p> <p>Information gathered during assessment including residents cultural beliefs and values is used to develop a care plan which the resident (if appropriate) and/or their family/whānau are asked to consult on. The staff come from a variety of cultural backgrounds which are reflective of the residents and assists in meeting resident cultural needs.</p>

<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>The facility has a staff code of conduct which states there will be zero tolerance against any discrimination occurring. The RN's supervise staff to ensure professional practice is maintained in the service. The abuse and neglect process covers harassment and exploitation. All residents interviewed reported that the staff respected them. Job descriptions include responsibilities of the position, ethics, advocacy and legal issues. The orientation and employee agreement provided to staff on induction includes standards of conduct.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service has policies to guide practice that align with the health and disability services standards to meet the needs of residents requiring residential disability, hospital level and secure dementia level of care. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training. The resident satisfaction survey reflects high levels of satisfaction with the services that are provided. Residents and relatives interviewed spoke very positively about the care and support provided. Staff interviewed had a sound understanding of principles of aged care and state that they feel supported by the management team.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Residents interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Ten incidents/accidents forms were viewed. The form includes a section to record family notification. All ten forms indicated family were informed or if family did not wish to be informed. Relatives interviewed confirm they are notified of any changes in their family member's health status. The service has introduced a process where all relatives or EPOA are contacted monthly by registered nurses to provide an update on the resident's condition.</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>CI</p>	<p>Hillcrest is owned and operated by the CHT Healthcare Trust. The service provides dementia, residential disability (physical) and hospital level care for up to 80 residents. On the day of the audit there were 69 residents including 17 dementia residents and 52 hospital level residents. This includes seven residents on YPD contracts (all in the hospital), four on long term chronic conditions contracts (one in the dementia unit and three in the hospital) and two residents on respite care (one in the hospital and one in the dementia unit). This audit has approved the 60 previously hospital level beds for the use of either hospital or rest home level residents (dual purpose). There were no rest home level residents on the days of audit. The service understands the needs of rest home level residents and have provided for their greater independence and ability to connect with the community.</p> <p>The unit manager is a registered nurse and maintains an annual practicing certificate. He has been in the role</p>

		<p>for one year and was previously working for two years as an RN at Hillcrest. The clinical coordinator has been in the role since January 2015 and was previously a charge nurse in another aged care service for five years. The unit manager reports to the CHT area manager weekly on a variety of operational issues. CHT has an overall business/strategic plan and Hillcrest Hospital has a facility quality and risk management programme in place for the current year. The organisation has a philosophy of care, which includes a mission statement. The unit manager has completed in excess of eight hours of professional development in the past 12 months. The service has exceeded the standard around implementation of the Pillars of Care.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>In the absence of the unit manager, the area manager is in charge, with support from the senior management team, the clinical coordinator and care staff.</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>There is an organisational business/strategic plan that includes quality goals and risk management plans for CHT Hillcrest. There is evidence that the quality system continues to be implemented at the service. Interviews with staff confirmed that quality data is discussed at three monthly quality/health and safety/staff meetings to which all staff are invited. The unit manager advised that he is responsible for providing oversight of the quality programme. The quality and risk management programme is designed to monitor contractual and standards compliance. The service's policies are reviewed at national level with input from facility staff every two years. New/updated policies are sent from head office. Staff have access to manuals. The assessment and care planning policy has been updated to include InterRAI.</p> <p>Resident/relative meetings are held. Restraint and enabler use is reported within the quality meetings.</p> <p>Data is collected in relation to a variety of quality activities and an internal audit schedule has been completed. Areas of non-compliance identified through quality activities are actioned for improvement. The service has a health and safety management system. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. There is a death/Tangihanga policy and procedure that outlines immediate action to be taken upon a consumer's death and that all necessary certifications and documentation is completed in a timely manner. Falls prevention strategies are implemented for individual residents and staff receive training to support falls prevention (link 1.2.1.1).</p>

		Residents are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families.
<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>	FA	There is an accidents and incidents reporting policy. The unit manager and clinical coordinator investigate accidents and near misses and analysis of incident trends occurs. There is a discussion of incidents/accidents at three monthly quality/health and safety/staff meetings including actions to minimise recurrence. Ten incident forms that were sampled documented clinical follow-up of residents is conducted by a registered nurse. One pressure area was noted not to have been documented on an incident report (link 1.3.6.1). Discussions with the unit manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications.
<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	There are human resource management policies in place, which include that the recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates is kept. Eight staff files were reviewed and evidence that reference checks are completed before employment is offered. The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. The in-service education programme for 2015 is being implemented. Health care assistants have completed an aged care education programme. Fourteen health care assistants who routinely work in the dementia unit have all completed the dementia standards. The unit manager and registered nurses are able to attend external training including sessions provided by the local DHB. Ten of eleven RNs are InterRAI trained. Annual staff appraisals were evident in five of the staff files reviewed and the other three were new to the service.
<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	CHT policy includes staff rationale and skill mix. Sufficient staff are rostered on to manage the care requirements of the residents. At least one registered nurse is rostered on at any one time and all registered nurses have a current first aid certificate. Advised that extra staff can be called on for increased resident requirements. Interviews with staff, residents and family members identify that staffing is adequate to meet the needs of residents.

<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>	FA	<p>The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Residents' files are protected from unauthorised access by being locked away in the nurses' stations. Informed consent to display photographs is obtained from residents/family/whānau on admission. Sensitive resident information is not displayed in a way so that other residents or members of the public can view it. Entries in records are legible, dated and signed by the relevant healthcare assistant or registered nurse. Individual resident files demonstrate service integration. This includes medical care interventions and records of the activities coordinator. Medication charts are in a separate folder.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>The service has comprehensive admission policies and processes in place. Residents receive an information pack outlining services able to be provided, the admission process and entry to the service. The unit manager screens all potential residents prior to entry and records all admission enquires. Residents and relatives interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the manager and clinical coordinator. The admission agreement form in use aligns with the requirements of the contracts. Exclusions from the service are included in the admission agreement. The information provided at entry includes examples of how services can be accessed that are not included in the agreement.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs. Relatives interviewed confirmed they were kept well informed about all matters pertaining to residents, especially if there is a change in the resident's condition.</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</p>	PA Low	<p>The medication management policies and procedures comply with medication legislation and guidelines. Medicines are appropriately stored in accordance with relevant guidelines and legislation. Medication administration practice complies with the medication management policy for the medication rounds sighted. Medication prescribed is signed as administered on the pharmacy generated signing chart. All non-packaged medications are signed for on one sheet with one signature for all medications. Registered nurses administer medicines. All staff that administer medication are competent and have received medication management training. The facility uses a blister pack medication management system for the packaging of all tablets. The RN on duty reconciles the delivery and documents this. Medical practitioners write medication charts and there</p>

guidelines.		was evidence of three monthly reviews by the GP. Seven of 18 medication charts sampled have correct indications for use documented for 'as required' medications. No residents self-administer medicines.
<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>	CI	There is a fully functional kitchen and all food is cooked on site by contracted kitchen staff. A food services manual is in place to guide staff. On admission, a resident nutritional profile is developed for each resident and this is provided to the kitchen staff. This document is reviewed at least six monthly as part of the care plan review. The kitchen is able to meet the needs of residents who require special diets and the kitchen manager works closely with the RNs on duty. The kitchen staff have completed food safety training. The kitchen manager and cooks follow a rotating seasonal menu, which is currently in the process of review by a dietitian. Temperatures of refrigerators, freezers and cooked foods are monitored and recorded. There is special equipment available for residents if required. All food is stored appropriately. Residents and the family members interviewed were very happy with the quality and variety of food served. The service has exceeded the standard around meeting the specific dietary needs of residents.
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	The service records the reasons for declining service entry to residents should this occur and communicates this decision to residents/family/whānau. Anyone declined entry is referred back to the referring agency for appropriate placement and advice.
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	All appropriate personal needs information is gathered during admission, in consultation with the resident and their relative where appropriate. Appropriate assessment tools were completed and assessments were reviewed at least six monthly or when there was a change to a residents health condition in files sampled. The InterRAI assessment tool is implemented. Care plans are developed on the basis of these assessments.
<p>Standard 1.3.5: Planning Consumers' service</p>	FA	One of the nine files long-term care plans reviewed described the support required to meet the resident's goals and needs and identified allied health involvement under a comprehensive range of template headings (link

<p>delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>		<p>1.3.6.1). Residents and their family/whānau are involved in the care planning and review process. Short-term care plans are in use for changes in health status. Staff interviewed reported they found the plans easy to follow.</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>PA Moderate</p>	<p>Turning charts, food and fluid charts and weight monitoring charts sighted indicate that appropriate interventions are provided, despite not all interventions being clearly outlined in care plans. Registered nurses (RNs) (including the clinical coordinator) and health care assistants report progress against the care plan each shift. One resident with a grad-one pressure area has not had this reported via the incident reporting process (link #1.2.4.3). Wound care plans were not completed for this pressure injury; however, progress notes describe appropriate interventions for this resident. If external nursing or allied health advice is required, the RNs will initiate a referral (eg, to the district nurse). If external medical advice is required this will be actioned by the GP. Staff have access to sufficient medical supplies (eg, dressings). Sufficient continence products are available and resident files include a continence assessment and plan. Specialist continence advice is available as needed and this could be described.</p> <p>Wound monitoring and wound management plans are in place for nine wounds including two pressure areas (both acquired prior to admission). Two of these wounds have comprehensive assessments. All wounds have been reviewed in appropriate timeframes. The RNs have access to specialist nursing wound care management advice through the district nursing service.</p> <p>Interviews with registered nurses, clinical coordinator and health care assistants demonstrated an understanding of the individualised needs of residents and report that two-hourly turns occur. Food and fluid charts are comprehensively completed as required.</p> <p>Care plan interventions and food and fluid charts demonstrate interventions to meet residents' needs. All two-hourly turning charts consistently document two-hourly turns.</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</p>	<p>PA Low</p>	<p>Three activities coordinators are employed part time to operate the activities programme over seven days, for all residents. Health care assistants also provide activities in the dementia unit. Two of the three activities coordinators (one of whom is an occupational therapist) have been on leave for the month prior to the audit and the full activities programme has not been provided during this time in the hospital. Each resident has an individual activities assessment on admission. From this information the registered nurses develop an individual activities plan as part of the care plan, with input from the activities staff. Each resident is free to choose whether they wish to participate in the group activities programme or their individual plan. Participation is monitored. Group activities reflect ordinary patterns of life and include planned visits to the community. There is a resident meeting for younger residents where activities are planned to meet their needs. The facility</p>

setting of the service.		is able to meet the recreation and activities requirements of potential rest home level residents. All long-term resident files sampled have a recent activities plan within the care plan and this is evaluated at least six monthly when the care plan is evaluated. Plans sampled in the dementia unit document activities to support the resident over the 24-hour period. Residents and families interviewed commented positively on the activity programme.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	The registered nurses evaluate all initial care plans within three weeks of admission. The long-term care plan is evaluated at least six monthly or earlier if there is a change in health status. There is at least a three-monthly review by the GP. All changes in health status are documented and followed-up. An RN signs care plan reviews. Resident files sampled demonstrate that short-term care plans are evaluated and resolved or added to the long-term care plan if the problem is ongoing. Where progress is different from expected, the service responds by initiating changes to the care plan.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The nurses initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs. Interviews and medical notes demonstrate that referrals and options for care were discussed with the family. The staff provided examples of where a resident's condition had changed and the resident was reassessed.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or	FA	There are implemented policies in place to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles are available and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals sighted, were labelled correctly and stored safely throughout the facility. Safety data sheets are available.

hazardous substances, generated during service delivery.		
<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>	FA	<p>The building has a current building warrant of fitness. There is a full-time maintenance person employed to address the reactive and planned maintenance programme. All medical and electrical equipment was recently serviced and/or calibrated. Hot water temperatures are monitored and are managed within 43-45°C. The facility has sufficient space for residents to mobilise using mobility aids. The external area is well maintained. Residents have access to safely designed external areas that have shade. Staff stated they had sufficient equipment to safely deliver the cares as outlined in the resident care plans. Any of the 60 rooms currently used for hospital level care are suitable to provide rest home level care. The unit manager reported that the facility intends to initially provide rest home level care in the rooms that have external access to the car park to encourage independence. All rooms have external access.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are an adequate number of toilets and shower/bathing areas for residents and separate toilets for staff and visitors. All hospital bedrooms have their own ensuites. Facilities in the dementia unit are communal. Toilets and showers have privacy systems in place. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares.</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</p>	FA	<p>All residents rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Residents are encouraged to personalise their bedrooms.</p>

setting.		
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>The communal areas include the main lounge, smaller lounges and dining areas in the dementia unit. There is a designated lounge for all 10-room 'suites' in the hospital. The communal areas are easily and safely accessible for residents.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>Contracted cleaning staff clean the facility. They have access to a range of chemicals, cleaning equipment and protective clothing. The standard of cleanliness is monitored through the internal audit programme. Residents and relatives interviewed were satisfied with the standard of cleanliness in the facility.</p> <p>All laundry is done off site except kitchen laundry, personal items and facecloths and hand washed clothes. Residents and relatives interviewed expressed satisfaction with the laundry service.</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>A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Six monthly fire evacuation practice documentation was sighted. A contracted service provides checking of all facility equipment including fire equipment. Fire training and security situations are part of orientation of new staff and include competency assessments. Emergency equipment is available at the facility. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and gas cooking. Short-term back up power for emergency lighting is in place.</p> <p>A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is available at all times.</p> <p>There are call bells in the residents' rooms and lounge/dining room areas. Residents were observed to have their call bells in close proximity.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And</p>	FA	<p>General living areas and all resident rooms are appropriately heated and ventilated. All rooms have external windows that open, allowing plenty of natural sunlight.</p>

<p>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>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>	FA	<p>Hillcrest Hospital has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system. A registered nurse is the designated infection control coordinator with support from the unit manager, the clinical coordinator and all staff as the quality management committee (infection control team). Minutes are available for staff. Spot audits have been conducted and includes hand hygiene and infection control practices. Education is provided for all new staff on orientation. The infection control programme has been reviewed annually.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>A registered nurse at Hillcrest Hospital is the designated infection control (IC) coordinator. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurse and IC team (comprising all staff) has good external support from the local laboratory infection control team and IC nurse specialist at the DHB. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current</p>	FA	<p>There are CHT infection control policies and procedures appropriate for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies have been reviewed and updated.</p>

accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.		
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred. The infection control coordinator has completed infection control training. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records.
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 control programme.	FA	Infection surveillance is an integral part of the infection control programme and is described in CHT's infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. Short-term care plans are used. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at quality meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the unit manager. There have been no outbreaks since the previous audit.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The service has documented systems in place to ensure the use of restraint is actively minimised. There were six hospital residents with restraint and six hospital residents with an enabler. Enabler use is voluntary. All necessary documentation has been completed in relation to the restraints. Staff interviews and staff records evidence guidance has been given on restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. Staff education on RMSP/enablers has been provided. Restraint has been discussed as part of quality meetings. A registered nurse is the designated restraint coordinator.

<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	<p>FA</p>	<p>A registered nurse is the restraint coordinator. Assessment and approval process for restraint use included the restraint coordinator, registered nurses, resident/or representative and medical practitioner.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>The service completes comprehensive assessments for residents who require restraint or enabler interventions. These were undertaken by suitably qualified and skilled staff, in partnership with the family/whānau in the two files sampled. The restraint coordinator, the resident and/or their representative and a medical practitioner were involved in the assessment and consent process. In the two restraint files reviewed, assessments and consents were fully completed.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>The restraint minimisation manual identifies that restraint is put in place only where it is clinically indicated and justified and approval processes. An assessment form/process is completed for all restraints and enablers. The files reviewed had a completed assessment form and a care plan that reflected risk. Monitoring forms that included regular two hourly monitoring (or more frequent) were present in the files reviewed. In resident files reviewed, appropriate documentation has been completed. The service has a restraint and enablers register, which is updated each month.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>The service has documented evaluation of restraint every three months. In the restraint files reviewed, evaluations had been completed with the resident, family/whānau, and the restraint coordinator. Restraint practices are reviewed on a formal basis every month by the facility restraint coordinator at quality meetings. Evaluation timeframes are determined by policy and risk levels.</p>

<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>The service actively reviews restraint as part of the internal audit and reporting cycle. Reviews are completed three monthly or sooner if a need is identified. Reviews are completed by the restraint coordinator. Any adverse outcomes are reported at the monthly quality meetings.</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)
Criterion 1.3.12.6 Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.	PA Low	All robotic sachet packed medications on medication records sampled (18) are signed as administered. All non-packaged medications are documented on one pharmacy generated sheet, which is signed with one signature when all these medications are administered. All residents have a medication chart that is signed by the doctor. For long-term residents these are pharmacy generated. Appropriate prescribing practices were sighted on seven of the 18 medication charts sampled.	i) Non-packaged, regular medications are not signed for individually for each medication, demonstrating that this has been administered. ii) In eleven of 18 charts sampled there is either no indication for use documented for 'as required' medications, or the pharmacy has generated a generic list of uses for that medication which is not specific to the resident for whom the medication is prescribed.	i) Ensure that all non-packaged medications have each medication individually signed as administered. ii) Ensure that indications for use are documented for all 'as required' medications and that these

				are specific to the resident.  60 days
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Moderate</p>	<p>All residents have a care plan that outlines needs in relation to areas determined by a set of templated headings or other individualised requirements. However, only one of the nine care plans sampled documented interventions for all identified needs. All nine wounds have a management plan documented and have been reviewed within the indicated timeframes. One resident with a pressure area (externally acquired) is under the care of the district nurse. Two wounds (including one of the two pressure areas) have comprehensive assessments. When a pressure area is identified, a comprehensive pressure area report is completed, assessing all the residents' needs including nutrition, pain management and interventions to reduce the risk of further pressure injury. A wound assessment and plan is intended to be documented and an incident form is completed. This had not occurred for one resident (link #1.2.4.3). The progress notes document this resident was receiving appropriate care for the grade one pressure area (which had previously been a grade two).</p>	<p>i) Eight of nine care plans (three dementia and five hospital) do not document interventions for all identified needs. Examples include culture, diabetes, asthma, COPD, hoist use and dermatitis; ii) seven of nine wounds do not have a comprehensive assessment documented; iii) one resident has a grade one pressure area as indicated by ongoing progress notes (now resolved). This was not identified as a pressure area so no incident form, pressure area report or wound assessment or management plan were completed.</p>	<p>i) Ensure care plans document interventions for all identified resident needs; ii) ensure that all wounds have a comprehensive assessment completed; iii) ensure that all pressure injuries are identified and that appropriate management is documented.</p> <p>60 days</p>
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that</p>	<p>PA Low</p>	<p>An activities programme that is varied, and meets the needs of individual residents and resident groups is documented. The activities programme is documented monthly and residents are provided with the programme weekly. The programme includes approximately twice-monthly bus rides for residents. Younger residents are also able to leave the facility independently or with family, or are supported to attend stroke club (two residents) twice weekly or to visit local shops. Two of the three activities</p>	<p>Two of the three activities coordinators had been on leave for the month prior to the audit and a full activities programme had not been provided in the hospital on Mondays, Tuesdays and Wednesdays.</p>	<p>Ensure a comprehensive activities programme is provided during each week for all residents.</p>

<p>are meaningful to the consumer.</p>		<p>coordinators had been on leave for the month prior to the audit. Health care assistants had continued to provide a varied programme in the dementia unit but a full activities programme had not been provided in the hospital on Mondays, Tuesdays and Wednesdays.</p>		<p>90 days</p>
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## Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<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>	CI	<p>CHT has an organisation wide mission with pillars of care that are known and implemented at CHT Hillcrest.</p>	<p>CHT’s logo is ‘We take great care of older people’.</p> <p>Underpinning this is CHTs five pillars of care: compassion, comfort, companionship, care and quality of life.</p> <p>In late 2013 CHT, including CHT Hillcrest focused on one of these five pillars of care ‘quality of life’ and looked at ways to reduce falls for its residents as it recognised that falls prevention is not an isolated goal but part of a larger objective of promoting activity and improving quality of life.</p> <p>The aim was to reduce residents’ falls, as it is a crucial aspect in reducing injury for residents.</p> <p>On investigating the reasons why residents fall at Hillcrest Hospital and analysing the trends, it was evident that a number of falls were as a result of residents trying to get out of bed unsupervised.</p> <p>Coupled with this was the use of bedrails as a falls management strategy in preventing residents from trying to get out of bed unaided. As with any form of restraint the service identified ongoing safety concerns and risks associated with restraint usage.</p> <p>As per CHTs restraint minimisation policy ‘CHT will promote quality of life for residents by ensuring the use of restraint is kept to a minimum, and only used to ensure the safety of the resident, staff and other residents or</p>

		<p>visitors to the unit'.</p> <p>In attempting to reduce falls associated with residents getting out of bed unaided, a decision was made to purchase ultralow beds. A total of twelve of these beds are now in use at CHT Hillcrest.</p> <p>The objectives were:</p> <ol style="list-style-type: none"> <li>1. Reduce resident falls</li> <li>2. Promote quality of life</li> <li>3. Educate staff, the resident and the family on falls management strategies</li> <li>4. Ensure CHTs falls management policy and other falls management documentation is current and reflects best practice</li> <li>5. Reduce the use of bedrails for maintaining resident safety.</li> </ol> <p>Falls are recorded in the electronic patient management system each month. This data is extracted monthly and analysed. The analysis includes identifying any specific trends for the resident, for example, time of fall, frequency of falls and number of falls over a rolling 12-month period. This information was graphed and is useful for highlighting to staff. Frequent fallers are also identified and from this, falls management strategies discussed at the monthly unit review meetings. This includes the use of low beds as a strategy. The unit manager, area manager and the CEO attend these meetings.</p> <p>Outcomes:</p> <p>There are a total of twelve ultra-low beds now in use at CHT Hillcrest. As a result of the use of these beds there has been:</p> <ul style="list-style-type: none"> <li>• A reduction in falls for residents using ultra low beds and a reduction in the potential for serious injury</li> <li>• Falls is now a standalone heading in the electronic care plan</li> <li>• The falls management policy has been updated</li> <li>• The falls checklist has been updated</li> <li>• There is a pictorial chart in place for each resident that identifies falls risk (sighted in resident's rooms)</li> <li>• The CHT manual handling programme has been updated</li> <li>• Manual handling champions include two HCAs and one RN. A physiotherapist trained the champions</li> <li>• Regular meetings with champions, to identify falls management strategies for particular residents at</li> </ul>
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			<p>Hillcrest</p> <ul style="list-style-type: none"> <li>There has been a reduction in the use of bedrails from 12 in December 2013 to four at the time of the audit, and improved quality of life. Four residents have had the use of bedrails stopped as a direct result of being provided with an ultra-low bed.</li> </ul>
<p>Criterion 1.3.13.2</p> <p>Consumers who have additional or modified nutritional requirements or special diets have these needs met.</p>	CI	<p>The facility has an appropriate food service in place for residents and all weights are monitored and documented monthly. There is dietitian input when weight loss is identified.</p>	<p>The service commenced using a Replenish Energy and Protein (REAP) programme in July 2012. REAP puts a focus on nutrition and 'nutrition alerts'. The documented programme has been developed by the external contractors dietitian and provides eligibility criteria and implementation guidelines for each level of REAP. There are three levels. The emphasis is on food first rather than commercial supplements for managing unintended weight loss. At Hillcrest there are currently 14 residents on REAP. These residents are clearly documented on the whiteboard in the kitchen. When a resident is identified as having unintended weight loss a weight loss report is completed. This includes checking the mouth and teeth, reviewing diet type, monitoring food intake, consulting with the cook, consulting the dietitian, referring to the GP, referring to family and reviewing medication. Three files were sampled for residents who have been on REAP. All were assessed by a dietitian prior to commencement on REAP. Each of the three residents on REAP whose files were sampled have had weight stabilisation with one having gained weight. All staff were provided with training around REAP by the external contractors dietitian with the kitchen staff receiving more detailed training. Health care assistants and registered nurses interviewed were all familiar with REAP and report the benefits to residents. The kitchen manager interviewed reports the ways in which she implements REAP, including fortifying food wherever possible for those on the programme. Examples include cream and brown sugar on cereals, extra margarine on vegetables, fortifying mashed potato, sauces and purees, cream on desserts in the evening, fortifying soup, providing fortified milk and fortified drinks, fortified custard for supper and sandwiches for supper. The service continues to evaluate and improve the REAP programme and initial results show a marked decrease in weight loss for those using the programme.</p>

End of the report.