# CHT Healthcare Trust - Waiuku Hospital and 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 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** CHT Healthcare Trust

**Premises audited:** Waiuku Hospital and Rest Home

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

**Dates of audit:** Start date: 11 January 2017 End date: 11 January 2017

**Proposed changes to current services (if any):** This audit has assessed the service as suitable to provide hospital (medical) level of care.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 58

# 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 |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

## General overview of the audit

Waiuku Hospital and Rest Home is a purpose built facility. The service provides care for up to 60 rest home and hospital residents. This audit also verified the service as suitable to provide hospital (medical) level of care. The current occupancy is 58 residents. Waiuku Hospital and Rest Home is part of the CHT organisation. The CHT group has strong board and effective governance practices. The manager is a registered nurse who has been in the role for three years. Resident and family feedback during the audit was very positive.   
The service had one shortfall identified at the previous audit around timeliness of wound review. While the specific issues have been addressed, improvement continues to be required around wound management. Improvement is also required about interventions documentation in care plans and infection surveillance.

The service has continued to exceed the required standard around meeting the nutritional needs of resident requiring management 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. |

Waiuku Hospital and Rest Home practices open disclosure with residents and family reporting they are well informed. Complaints processes are implemented and there is a complaints register.

## Organisational management

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| --- | --- | --- |
| 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. |  | Standards applicable to this service fully attained. |

Waiuku Hospital and Rest Home has a current business plan and a quality assurance and risk management programme that outlines objectives for the next year.

The quality process continues to be implemented and includes regularly reviewed policies, an internal audit programme and a health and safety programme that includes hazard management. Residents and relatives are provided the opportunity to feedback on service delivery issues at three monthly resident meetings and via annual satisfaction surveys. There is a reporting process being used to record and manage resident incidents. Incidents have been collated monthly.

Waiuku Hospital and Rest Home has job descriptions for positions that include the role and responsibilities of the position. There is an annual in-service training programme that has been implemented for the year and staff are supported to undertake external training. There is an annual performance appraisal process in place.

The service has a documented rationale for determining staffing and healthcare assistants, residents and family members reported staffing levels are sufficient to meet resident needs.

## 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 medium or high risk and/or unattained and of low risk. |

Resident records reviewed provide evidence that the registered nurses utilise the InterRAI assessment to assess, plan and evaluate care needs of the residents. Care plans are developed in consultation with the resident and/or family. Care plans demonstrate service integration. Resident files include three monthly reviews by the general practitioner. There is evidence of other allied health professional input into resident care.

Medication policies reflect legislative requirements and guidelines. All staff responsible for administration of medicines complete education and medicines competencies. The medicine electronic records reviewed included documentation of allergies and sensitivities and are reviewed at least three monthly by the general practitioner.

There are activities programmes in place for all residents. The programme includes community visitors and outings, entertainment and activities that meet the recreational preferences and abilities of the residents.

All food and baking is done on site by an external contractor. All residents' nutritional needs are identified and documented. Choices are available and are provided.

## Safe and appropriate environment

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| --- | --- | --- |
| 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. |

Waiuku Hospital and Rest Home holds a current warrant of fitness.

## Restraint minimisation and safe practice

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| --- | --- | --- |
| 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. |

There is a documented definition of restraint and enablers that aligns with the definition in the standards. There is a restraint register and a register for enablers. There are currently seven residents requiring restraints and one resident using an enabler. Staff are trained in restraint minimisation and challenging behaviour management.

## Infection prevention and control

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| 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. |  | Some standards applicable to this service partially attained and of low risk. |

The infection control coordinator is a registered nurse. Infection information is collected monthly.

## Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **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** | 1 | 13 | 0 | 1 | 1 | 0 | 0 |
| **Criteria** | 1 | 36 | 0 | 1 | 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)** |
| **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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **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 | Information about complaints is provided on admission. Interview with residents informed an understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints. There is a complaints register. Complaints for 2016 (six in total) were reviewed.  All complaints included investigation, timelines, corrective actions when required and resolutions. Results have been fed back to complainants.  Discussions with residents and family members confirmed that any issues have been addressed and they feel comfortable to bring up any concerns. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Twelve incidents/accidents forms were viewed. All twelve forms indicated family were informed or if family did not wish to be informed. On interview five residents (three rest home and two hospital), five family members (two rest home and three hospital) and five healthcare assistants, one registered nurse, one activities coordinator and the acting clinical coordinator all stated that family have been kept informed following changes in the residents’ health status. Contact records were documented in all files reviewed.  Families often give instructions to staff regarding what they would like to be contacted about and when should an accident/incident of a certain type occur. This is documented in the resident files. A residents meeting occurs three monthly and issues arising from the meeting are fed back to staff meetings. Issues raised are addressed.  There is a policy that describes the availability of interpreter services when required.  Residents and family are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Waiuku Hospital and Rest Home is a purpose built rest home and hospital facility. The service provides care for up to 60 rest home and hospital residents. This audit has also assessed the service as suitable to provide hospital (medical) level of care. The occupancy on audit day was 13 rest home residents including one on respite and 45 hospital residents. All beds are dual-purpose. Waiuku Hospital and Rest Home is part of the CHT organisation. Waiuku Hospital and Rest Home has a current business plan and a quality assurance and risk management programme that outlines objectives for the next year and aligns with the CHT operational strategic goals and business plan.  The manager is a registered nurse who has been in the role for three years and has been in management roles with CHT for almost 20 years. The clinical coordinator position is currently on leave and in the interim a senior registered nurse is acting in this position. The unit manager and (acting) clinical coordinator cover all on-call. The manager has completed ongoing training appropriate to the position. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | Waiuku Hospital and Rest Home has a quality framework that is being implemented. There is a quality assurance plan which includes internal audit, incident collation, infection surveillance and hazard management. Interviews with staff informed an understanding of the quality activities undertaken at Waiuku Hospital and Rest Home. All quality data (except infections – link 3.5.7) is analysed and staff informed of the outcomes of trend analysis. Resident meetings occur three monthly. Annual surveys have been conducted of residents and relatives by an external agency. The survey conducted in 2016 indicated a high level of satisfaction. Following the staff survey results in 2016, staff focus groups were held with a smaller group of staff focussing on the area of poorest outcome across the organisation. Staff interviewed reported improvements following this process.  The area manager completes a six monthly internal spot audit covering all areas of the service. All issues found in the 2016 audits have identified corrective action plans and resolutions (where the resolution is due). Results of audits are discussed in staff meetings.  The service has appropriate policies/procedures to support service delivery; Policies and procedures align with the client care plans.  Falls prevention strategies include physiotherapy reviews and instruction around prevention in care plans. There is a hazard register that is reviewed regularly. All hazards are reported on a hazard form and documented as closed when corrective and preventative actions are complete. There is an active health and safety committee led by a competent and well trained health and safety team leader. The process to address health and safety meets current legislative requirements. |
| Standard 1.2.4: Adverse Event Reporting  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. | FA | The service collects a comprehensive set of data relating to adverse, unplanned and untoward events. Once incidents and accidents are reported, the immediate actions taken and interventions to minimise the risk of recurrence, are documented. The incidents forms are then reviewed and investigated by the clinical coordinator who monitors issues. If risks are identified these are also processed as hazards. Incidents are trended monthly and a report is reported to the facility meetings. Incident forms reviewed documented appropriate process and clinical management of incidents. Discussion with the service indicates that management are aware of and are able to describe their statutory requirements in relation to essential notification. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | There are job descriptions available for positions that describe staff roles, responsibilities and accountabilities. A sample of six staff files (the acting clinical coordinator, one registered nurse, an activities coordinator and two healthcare assistants) demonstrated that staff have employment documentation including employment contracts, job descriptions, interview records, reference checks and current visas where applicable. The practising certificates of RNs are current. The service also maintains copies of other visiting practitioner’s certification. Orientation and training records were documented in each of the staff files sampled.  There is an annual appraisal process in place and appraisals are current in all staff files reviewed.  Newly appointed staff complete an orientation that was sighted in all files reviewed. Interviews with staff described the orientation programme that includes a period of supervision. Supervision can be extended if needed. The service has a training policy and schedule for in-service education that is implemented. Interview with staff informed there is access to sufficient training.  There are implemented competencies for registered nurses related to specialised procedure or treatment including (but not limited to); medication and syringe driver. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. Care staff reported that staffing levels and the skill mix was appropriate and safe. All residents and family members interviewed stated that they felt there was sufficient staffing.  In addition to the acting clinical coordinator, who works Monday to Friday, there are two registered nurses on the morning and afternoon shift and one overnight.  A contracted physiotherapist attends the facility for eight hours a week. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | 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 round sighted. The facility uses an electronic medication management system. Medication prescribed is signed as administered electronically. Registered nurses and medication competent HCAs administer medicines. All staff that administer medicines are competent and have received medication management training. The facility uses a robotically packed medication management system for the packaging of all tablets. The RN on duty reconciles the delivery and documents this. Medical practitioners (GPs) prescribe medications electronically. These were charted correctly and there was evidence of three monthly reviews by the GP. Two residents self-administer their own medicines and the documentation was correctly recorded and a competency assessment completed.  Ten medication charts were reviewed. All electronic charts had a photo ID, allergy status was recorded and ‘as required’ medications had prescribed indications for use. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | CI | There is a food services manual in place to guide staff. All food is cooked on site. A resident nutritional profile is developed for each resident on admission and 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 need special diets. The RNs inform the kitchen manager of any residents with specific nutritional needs, food allergies, or food likes or dislikes. The kitchen staff have completed food safety training. The kitchen manager and cooks follow a rotating seasonal menu, which has been reviewed by a dietitian. The 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 maintained the continuous improvement rating awarded at the previous certification audit around meeting the specific dietary needs of residents. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Moderate | Registered nurses (RNs) and healthcare assistants (HCAs) follow the care plan and report progress against the care plan each shift at handover. If external nursing or allied health advice is required, the RNs will initiate a referral (eg, to the wound care nurse specialist or the mental health team). If external medical advice is required, this will be actioned by the GPs. Staff have access to sufficient medical supplies (eg, dressings). Sufficient continence products are available and resident files include a continence assessment and plan as part of the plan of care. Specialist continence advice is available through the DHB  Wound assessment, monitoring and wound management plans are in place for eleven wounds (one chronic leg ulcer, one resident with multiple minor scratches and abrasions which are self-inflicted, one skin carcinoma, and five skin tears) and three residents with pressure injuries. All wounds have been reviewed in appropriate timeframes. This shortfall identified in the previous audit had been addressed. However, this audit identified that not all wound management plans included a comprehensive assessment of the wound with consistent evaluation. The RNs have access to specialist nursing wound care management advice through the DHB.  Interviews with registered nurses and HCAs demonstrated an understanding of the individualised needs of residents. Not all care plans demonstrated interventions to meet residents’ needs. There was evidence of pressure injury prevention interventions such as two hourly turning charts, use of pressure relieving equipment. Food and fluid charts, regular monitoring of bowels and regular (monthly or more frequently if required) weight management. The service has continued to implement the REAP plan around weight management for residents with initial results showing improved outcomes for residents with weight loss.  Monitoring forms such as weight, observations and wounds are in use as applicable. Behaviour charts were in use for any residents that exhibit challenging behaviours. |
| Standard 1.3.7: Planned Activities  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. | FA | Three activities staff (one full time, one part time and one casual) deliver the activities programme over seven days per week. Each resident has an individual activities assessment on admission, which is incorporated into the InterRAI assessment process. An individual activities plan is developed for each resident by the activities coordinators in consultation with the registered nurses. Each resident is free to choose whether they wish to participate or not. There is a wide variety of activities available. Those who prefer to stay in their room have a one-on-one visit. Participation is monitored. There are van outings to community events, sightseeing and shopping. Church services are available for all denominations. All long-term resident files sampled have an activity plan within the care plan and this is evaluated at least six monthly when the care plan is evaluated or a further InterRAI assessment occurs. Residents interviewed commented positively on the activity programme.  The facility has recently introduced a mobility club, following feedback received from some residents. The aim of the club is to assist residents to improve or maintain their current level of mobility and fitness. A small gym area has been created with equipment that residents are able to use under the supervision of the activity staff. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Three of four long-term resident files sampled demonstrated that the InterRAI assessment and long-term care plan were evaluated at least six monthly or earlier if there was a change in health status (link 1.3.6.1). There was at least a three monthly review by the GP. Short-term care plans sighted were evaluated and resolved or added to the long-term care plan if the problem is ongoing, as sighted in resident files sampled. |
| 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 Waiuku Hospital and Rest Home facility holds a current warrant of fitness that expires on 1 September 2017. The available equipment is suitable to provide hospital (medical) level of care. |
| 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. | PA Low | Infection monitoring is the responsibility of the infection control coordinator.  The infection control coordinator enters infections onto the infection register and the CHT process includes carrying out a monthly analysis of the data. This has not been documented regularly in 2016. The infection control coordinator was reported to use the information obtained through the surveillance of data to determine infection control education needs within the facility. GPs are notified if there is any resistance to antimicrobial agents. There is evidence of GP involvement and laboratory reporting. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | Staff were familiar with the policy and the definition of enablers. Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective.  The restraint manual determines that enablers are voluntary and the least restrictive option. There was one enabler in use in the facility and review of the file demonstrated that restraint use is voluntary. There were seven residents with eight restraints. |

# 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 1.3.6.1  The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Moderate | Wound management was documented and implemented for all wounds however; wound documentation was not evidenced to be fully completed. Pressure injury assessments, management and the management of associated risks were documented. Monitoring records were well documented including two hourly turning charts and food and fluid charts. Respite residents have an initial nursing assessment and care plan completed. Three of five care plans sampled documented interventions for identified needs. | (i) Two of three pressure injuries and five of seven minor injuries did not have a comprehensive wound assessment completed to document the type and size of wound currently being treated;  (ii) Two wound management plans (one pressure injury and one skin carcinoma) did not evidence consistent detailed evaluation to assist with the monitoring of progress of wound healing;  (iii) One hospital resident with a change to mobility and nutritional needs following a recent discharge from hospital, did not have the care plan updated to reflect changes to resident’s needs and one rest home respite resident did not have an initial nursing assessment and care plan updated to reflect changes in the resident’s needs. | (i-ii) Ensure all wound assessments document the type and size that is being treated, and that evaluations are documented in enough detail to enable monitoring of progress towards the desired goal; and  (iii) Ensure care plans are completed and updated to reflect resident needs.  60 days |
| Criterion 3.5.7  Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner. | PA Low | The infection control coordinator collates the individual forms completed for every infection and enters them onto a monthly tally. Interviews demonstrated an overview and informal analysis of this data but there was no evidence of trend analysis documented. This issue had been identified in the internal audit in September 2016 but the issue had not been addressed. | Analysis of infection control surveillance data had not been documented for 11 of 12 months in 2016. | Ensure that infection control surveillance data is analysed for trends and that this is documented.  90 days |

# 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** |
| Criterion 1.3.13.2  Consumers who have additional or modified nutritional requirements or special diets have these needs met. | CI | There is a seasonal menu in place. Alternative menu choices are available for residents with specific dietary needs or food preferences. Residents are weighed monthly or as prescribed by the GP or dietitian. Residents who had had unintentional weight loss are reviewed by a dietitian and commenced on the Replenish Energy and Protein Programme. | The service commenced using a Replenish Energy and Protein (REAP) programme in July 2012 for residents who are identified at risk of developing malnutrition or those who have had unintentional weight loss. There are three levels. The emphasis is on food first rather than commercial supplements for managing unintended weight loss. There are currently four residents on REAP. These residents are clearly documented on the whiteboard in the kitchen. When a resident is identified as having unintentional 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. Four files were sampled for residents who have been on REAP programme. All four residents’ files evidenced weight gain and that weight was now stabilised with no further weight loss identified over a six month period. The service continues to evaluate and implement the REAP programme and results continue to show a marked decrease in weight loss for those using the programme. |

End of the report.