# T M & D L Beer Holdings Limited - Cardrona Rest Home & Hospital

## 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](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:** T M & D L Beer Holdings Limited

**Premises audited:** Cardrona Rest Home & Hospital

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

**Dates of audit:** Start date: 8 June 2017 End date: 9 June 2017

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

**Total beds occupied across all premises included in the audit on the first day of the audit:** 26

# 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

Cardrona Rest Home provides rest home and hospital level care for up to 35 residents. On the day of audit, there were 26 residents. The service is managed by a general manager (non-clinical) and a clinical operations manager/registered nurse. The residents and relatives interviewed all spoke positively about the care and support 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, staff and management.

There are well-developed systems, processes, policies and procedures that are structured to provide appropriate quality care for people who use the service. Implementation is supported through the quality and risk management programme. Quality initiatives are implemented which provide evidence of improved services for residents.

A comprehensive orientation and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support, is in place.

The facility has embedded the interRAI assessment protocols within its current documentation. Care plans were individualised and comprehensively completed for all resident files reviewed. ‘At risk’ residents were identified and monitoring strategies were implemented and regularly evaluated.

The service is to be commended on the achievement of continuous improvement ratings around best practice and nutrition.

## Consumer rights

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

Information about services provided is readily available to residents and families. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is presented to residents and their families during entry to the service. Policies are implemented to support rights such as: privacy; dignity; abuse and neglect; culture; values and beliefs; complaints; advocacy; and informed consent. Care planning accommodates individual choices of residents and/or their family/whānau. Residents are encouraged to maintain links with the community. Residents and family report communication with management and staff is open and transparent. There is a complaints management process in place and a complaint register is documented.

## 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. |

Services are planned, coordinated and are appropriate to the needs of the residents. A clinical operations manager/registered nurse and a general manager are responsible for the day-to-day operations of the care facility. The clinical operations manager/registered nurse is supported by a registered nurse (second in charge) and team of care staff. Quality and risk management processes are implemented. Quality goals are documented for the service. A risk management programme is in place, which includes a risk management plan, incident and accident reporting and health and safety processes. The health and safety programme meets current legislative requirements. Adverse, unplanned and untoward events are documented and investigated. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. A staff education and training programme is embedded into practice. Registered nursing cover is provided twenty-four hours a day, seven days a week. There are adequate numbers of staff on duty to ensure residents are safe. The residents’ files are appropriate to the service type.

## Continuum of service delivery

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

The clinical operations manager/registered nurse takes primary responsibility for managing entry to the service with assistance from the registered nurses. Comprehensive service information is available. Initial assessments are completed by a registered nurse, including interRAI assessments. The registered nurses complete care plans and evaluations within the required timeframes. Care plans are based on the interRAI outcomes and other assessments. Residents interviewed confirmed they were involved in the care planning and review process. Each resident has access to an individual and group activities programme. The group programme is varied and interesting. Medicines are stored and managed appropriately in line with legislation and guidelines. General practitioners review residents at least three-monthly or more frequently if needed. Meals are prepared on-site and the menu has been reviewed by a dietitian. The menu is varied and appropriate. Individual and special dietary needs are catered for. Residents interviewed were complimentary about the food service.

## 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. |

The building has a current warrant of fitness and emergency evacuation plan. Ongoing maintenance issues are addressed. Rooms are individualised. There are several lounges and a spacious dining area. There are adequate toilets and showers. The internal areas are ventilated and heated. There is sufficient space to allow the movement of residents around the facility using mobility aids. The outdoor areas are safe and easily accessible. Cleaning services are well monitored through the internal auditing system. Laundry is completed on-site by dedicated laundry staff.

There is an emergency management plan in place and adequate civil defence supplies in the event of an emergency for residents and staff.

## 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. |

Restraint minimisation and safe practice policies and procedures are in place. Staff receive training in restraint minimisation and challenging behaviour management. The restraint coordinator is a registered nurse who is responsible for ensuring restraint management processes are followed. On the day of audit, there was one resident with restraint and three residents using an enabler.

## 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. |  | 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.

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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** | 0 | 50 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 2 | 99 | 0 | 0 | 0 | 0 | 0 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Unattained Negligible Risk****(UA Negligible)** | **Unattained Low Risk****(UA Low)** | **Unattained Moderate Risk****(UA Moderate)** | **Unattained High Risk****(UA High)** | **Unattained Critical Risk****(UA Critical)** |
| **Standards** | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 |

# Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](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 1.1.1: Consumer Rights During Service DeliveryConsumers receive services in accordance with consumer rights legislation. | FA | The Code of Health and Disability Consumers’ Rights (the Code) brochures are provided to residents and their families. Policy relating to the Code is implemented. Two managers (one general manager and one clinical operations manager/registered nurse) and seven care staff (four caregivers, two registered nurses (RNs) and one diversional therapist) interviewed confirmed their understanding of the Code and provided examples of how the Code is applied to residents’ cares. Staff receive training about the Code during their induction to the service. This training continues through the mandatory staff education and training programme.  |
| Standard 1.1.10: Informed ConsentConsumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Informed consent processes are discussed with residents and families on admission. The resident or their EPOA signs written consents. Six resident files sampled (two rest home- including one respite resident and four hospital- including one resident admitted under a young person with disability contract and one resident admitted under a long term chronic health conditions agreement) demonstrated that advanced directives are signed for separately. There is evidence of discussion with family when the GP has completed a clinically indicated not for resuscitation order. Caregivers and registered nurses interviewed confirmed verbal consent is obtained when delivering care. Family members are involved in decisions that affect their relative’s lives. All resident files sampled had a signed admission agreement signed on or before the day of admission and consents. |
| Standard 1.1.11: Advocacy And SupportService providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | HDC advocacy brochures are included in the information provided to new residents and their family during their entry to the service. An advocacy poster is displayed in a visible location. A resident advocate has been appointed to the service with contact details posted in a visible location. Staff receive regular education and training on the role of advocacy services, which begins during their induction to the service. Education is provided by the local HDC advocacy service.Residents and family interviewed were aware of the role of advocacy services and their right to access support. The complaints process is linked to advocacy services. |
| Standard 1.1.12: Links With Family/Whānau And Other Community ResourcesConsumers are able to maintain links with their family/whānau and their community.  | FA | The service has an open visiting policy. Residents may have visitors of their choice at any time. The service encourages the residents to maintain their relationships with friends and community groups. Assistance is provided by the care staff to ensure that the residents participate in as much as they can safely and desire to do, evidenced through interviews and observations. Interviews with residents confirmed that they are encouraged to remain active in their community and participate in social activities external to the aged care facility. Examples include van outings, shopping trips and church services. Local entertainers regularly visit the facility. |
| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.  | FA | The complaints procedure is provided to residents and families during entry to the service. Access to complaints forms are located at reception. A register of all complaints received is maintained. There have been no complaints received (verbal or written) since 2015. Residents and families interviewed confirmed they had no complaints or concerns about the service and found the staff and management very approachable. Discussions with residents and families/whānau confirmed they were provided with information on the complaints process and remarked that any concerns or issues they had were addressed promptly. |
| Standard 1.1.2: Consumer Rights During Service DeliveryConsumers are informed of their rights. | FA | Details relating to the Code and the Health and Disability Advocacy Service are included in the resident information that is provided to new residents and their families. The clinical operations manager/registered nurse and staff discuss aspects of the Code with residents and their family on admission. Discussions relating to the Code are also held during the monthly resident/family meetings. All six residents (three rest home- including one respite resident and three hospital- including one resident admitted under a young person with disability contract and one resident admitted under a long term chronic contract) and five families (rest home) interviewed, reported that the residents’ rights were being upheld by the service. The service encourages the young people with disabilities to go on outings in the community and to access services in the community that are of interest to them. The service promotes access to family and friends. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And RespectConsumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | Families and residents interviewed advised that residents are encouraged to make their rooms their own. Residents are encouraged to use personal belongs to decorate and furnish (as appropriate) their rooms. Privacy signage is on communal toilet doors. The care staff interviewed reported that they knock on bedroom doors prior to entering rooms, ensure doors are shut when cares are being given and do not hold personal discussions in public areas. They reported that they promote the residents' independence by encouraging them to be as active as possible. The staff interviewed were able to describe how they support the young people with disabilities to maintain their personal, gender, sexual, cultural, religious and spiritual identities. All of the residents and families interviewed confirmed that the residents’ privacy is respected. Guidelines on abuse and neglect are documented in policy. Staff attend mandatory education and training on abuse and neglect, which begins during their induction to the service. Links are in place with Age Concern for referral if abuse and/or neglect is suspected. |
| Standard 1.1.4: Recognition Of Māori Values And BeliefsConsumers 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. | FA | The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. The care staff interviewed reported that they value and encourage active participation and input from the family/whānau in the day-to-day care of the residents. Links are established with the local Mangakaretu Marae. Resident rooms are blessed following a death.Staff education on cultural awareness begins during their induction to the service and continues as a regular in-service. There is a flip chart in the nurse’s office with guidelines on Tikanga principles related to care. The caregivers interviewed provided examples of how they ensure Māori values and beliefs are upheld by the service. There were no resident living at the facility that identified as Māori during the audit. Cultural values and beliefs that are identified are documented in the resident’s care plan. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And BeliefsConsumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.  | FA | The service identifies the residents’ personal needs and desires from the time of admission. This is achieved in collaboration with the resident, family and/or their representative. The staff demonstrated through interviews and observations that they are committed to ensuring each resident remains a person, even in a state of decline. Beliefs and values are discussed and incorporated into the residents’ care plans, which was evidenced in all six care plans reviewed (two rest home- including one respite resident and four hospital- including one resident admitted under the young person with disability contract and one person admitted under the long term chronic health care contract). Residents and family interviewed confirmed they were involved in developing the resident’s plan of care, which included the identification of individual values and beliefs. |
| Standard 1.1.7: DiscriminationConsumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Professional boundaries are discussed with each new employee during their induction to the service. Professional boundaries are also described in job descriptions. Interviews with the care staff confirmed their understanding of professional boundaries including the boundaries of the caregivers’ role and responsibilities. Professional boundaries are reconfirmed through education and training sessions, staff meetings and performance management if there is infringement with the person concerned. |
| Standard 1.1.8: Good PracticeConsumers receive services of an appropriate standard. | FA | Good practice was evident. A registered nurse is on-site 24 hours a day, 7 days a week. A GP visits the service fortnightly and then as required. Residents are reviewed by the GP at least every three months. The service receives support from the district health board (DHB) which includes (but is not limited to) specialist visits (gerontology nurse specialist and mental health services). Support is also provided through Hospice New Zealand. Physiotherapy services are available on an as needed basis through a local provider and/or the DHB community physiotherapist.The clinical operations manager/registered nurse has completed her post-graduate Diploma in Health Science advanced nursing stream, specialising in common and chronic health conditions (June 2016). Commencing in Feb 2017, she is now authorised to implement standing orders for one GP at the Tokoroa Medical Centre, for common/uncomplicated conditions.A van is on-site for regular outings. Residents and family/whānau interviewed reported that they are either satisfied or very satisfied with the services received. A resident/family satisfaction survey is completed annually and confirmed satisfaction with the services received.The GP was unavailable for interview.  |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | The open disclosure policy is based on the principle that residents and their families have a right to know what has happened to them and to be fully informed at all times. The policy also describes that open disclosure is part of everyday practice. The care staff interviewed understood about open disclosure and providing appropriate information and resource material when required.Families interviewed confirmed they are kept informed of the resident`s status, including any events adversely affecting the resident. A family communication sheet is held in the front of the residents’ files. The clinical operations manager/registered nurse reports that she contacts family a minimum of monthly to update them on the resident’s health status. Nine accident/incident forms reviewed reflected documented evidence of families being informed following an adverse event. An interpreter service is available and accessible if required through the citizens advice bureau or DHB. Families and staff are utilised in the first instance. |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Cardrona Rest Home and Hospital provides care for up to 35 residents across rest home and hospital levels of care and on the day of audit there were 26 residents. There were twenty-one rest home residents- including one respite resident and five hospital residents- including two residents admitted under the young person with disability contract and one resident admitted under the long term chronic health care contract. The services are provided over two levels connected by a small internal ramp. The lower wing has fifteen beds including one double room and the upper wing has twenty beds including five double rooms. There are 12 dual-purpose beds. There are eleven dual purpose beds located on the upper level (four hospital and one rest home) and one dual purpose bed located on the lower level (one hospital resident).An annual business plan has been developed that includes a philosophy, values and measurable goals. The service organisation philosophy reflects a person/family centred approach. Business goals documented for 2016 have been reviewed and summarised and the 2017 business plan has been documented and is being implemented. The general manager was employed in February 2015. The general manager is responsible for all non-clinical related activities for two aged care facilities with the same ownership. Previous experience was held with the Ministry of Primary Industries. The general manager is on-site at Cardrona Rest Home at least three days per week. She is supported by a clinical operations manager/registered nurse who works at this site and another site owned by the same owners in another town. She has worked in the aged care sector for 18 years and holds a post-graduate qualification in Advanced Nursing. The clinical operations manager/registered nurse has been at this facility for approximately seven years. The clinical operations manager/registered nurse is on-site at Cardrona Rest Home two days per week. Both managers have completed at least eight hours of training related to management of an aged care facility, relevant to their role and responsibilities. |
| Standard 1.2.2: Service Management 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.  | FA | During the absence of the clinical operations manager/registered nurse, the second in charge (2IC) RN assumes clinical responsibilities. All non-clinical and administrative responsibilities are delegated to the general manager. The clinical operations manager is responsible for administrative responsibilities in the absence of the general manager. The business owner (non-clinical) is also available for support in the absence of the general manager.  |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | A quality and risk management programme is in place. Interviews with the general manager, clinical operations manager/registered nurse, care staff, one cook, one cleaner and one laundry staff member, reflected their understanding of the quality and risk management systems that have been put into place. Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards- including those standards relating to the Health and Disability Services (Safety) Act 2001. A document control system is in place. Policies are regularly reviewed. Policies and procedures have been updated to include reference to interRAI, health and safety and pressure injury management. New policies or changes to policy are communicated to staff, evidenced in meeting minutes. Staff are requested to sign that they have read the new/revised policies.Quality data collected is collated and analysed using a run chart methodology. Quality data is regularly communicated to staff via monthly staff meetings and using graphs and run charts that are posted each month in the staff areas. The service has implemented a comprehensive project around falls management, however the falls data is skewed by the number of frequent fallers. An internal audit programme is being implemented. Areas of non-compliance include the initiation of a corrective action plan with corrective actions signed off to evidence their implementation. There was evidence in the monthly staff meetings to verify staff are informed of audit results and any corrective actions required. A quality improvement register is maintained that keeps a running tally of quality initiatives. Examples since the last audit included (but were not limited to): refurbishing the lower area; purchasing a set of wheelchair scales; installing a heat pump in the conservatory; upgrading the shower areas; and installing Wifi access throughout the building. A health and safety programme is in place that meets current legislative requirements. An interview with the health and safety officer (clinical operations manager) and review of health and safety documentation confirmed that legislative requirements are being met. External contractors have been orientated to the facility’s health and safety programme. The hazard register is regularly reviewed (last review 4 November 2016).There was evidence that the young people with disabilities living at Cardrona Rest Home have input into quality improvements to the service via the resident meetings and discussion with the clinical manager and the cook.  |
| 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 | An accidents and incidents reporting policy is in place. There was evidence to support actions are undertaken to minimise the number of incidents. Clinical evaluation of residents following an adverse event is conducted by a registered nurse and was evidenced in all nine accident/incident forms selected for review. Adverse events are linked to the quality and risk management programme. Staff are kept informed in a timely manner regarding accidents and incidents and the implementation of strategies to reduce the number of adverse events. The general manager and the clinical operations manager/registered nurse are aware of the requirement to notify relevant authorities in relation to essential notifications.  |
| 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 human resources policies to support recruitment practices. A list of practising certificates is maintained. Six staff files were reviewed (clinical operations manager, registered nurse, caregiver, diversional therapist, maintenance and cook) and all had relevant documentation relating to employment. Performance appraisals are current in all files reviewed.Copies of practising certificates are kept on file. The service has implemented an orientation programme that provides new staff with relevant information for safe work practice. Evidence of completed induction checklists were sighted in all six staff files. Annual staff appraisals were up to date. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme includes documented competencies and induction checklists. Staff interviewed (four caregivers and two registered nurses) were able to describe the orientation process and believed new staff were adequately orientated to the service.There is an education plan being implemented that includes the required education as part of the Health and Disability Sector Standards and the ARRC contract. There is evidence that additional training opportunities are offered to registered nurses such as attendance at the education provided at the local GP practice and attendance at study days at the DHB. Care staff interviewed are aware of the requirement to complete competency training– such as medication and restraint competencies which were sighted in the files sampled.The RN’s are all first aid trained and four of seven RN’s are interRAI trained. Ten of eleven care staff have completed ACE qualifications or are enrolled in and completing NZQA qualifications.  |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | Policy includes staff rationale and skill mix. Sufficient staff are rostered to manage the care requirements of the residents. There is a registered nurse rostered on each shift for 26 residents (21 rest home and 5 hospital residents). A clinical operations manager/registered nurse is on-site on the floor as the registered nurse two days a week. Additional registered nurse cover can be provided to support the clinical needs of the residents and where required, an additional registered nurse may be rostered on the same day as the clinical operations manager/registered nurse is on-site.On an AM shift, there are two caregivers and on a PM shift, there are two caregivers plus an additional short shift that is filled based on resident need. The night shift is staffed with two caregivers. Extra staff can be called on for increased resident requirements. Activities staff are rostered on five days a week. There are separate domestic staff that are responsible for cleaning and laundry services.Interviews with staff, residents and family members identified that staffing is adequate to meet the needs of residents. |
| Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The residents’ files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry. An initial support plan is also developed in this time. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents’ files are protected from unauthorised access by being held in secure rooms. Archived records are secure in a separate locked storage facility located on the premises. Residents’ files demonstrate service integration. Entries are legible, dated, timed and signed by the carer and include their designation. |
| Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | The service has comprehensive admission policies and processes in place. Prior to entry all potential residents have a needs assessment completed by the needs assessment and coordination service to assess suitability for entry to the service. Residents receive an information pack outlining services able to be provided, the admission process and entry to the service. The clinical operations manager/registered nurse screens all potential residents prior to entry and records all admission enquires in a hard copy system. Residents and relatives interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the general manager and the clinical operations manager. The admission agreement form in use aligns with the requirements of the ARRC contract. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.  | FA | 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. A transfer form accompanies residents to receiving facilities. Relatives are notified if transfers occur. |
| 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 | Twelve medication charts were reviewed (six rest home- including one respite resident and six hospital- including one resident admitted under a YPD contract and one person admitted under a long term chronic health care contract). There are policies available for safe medicine management that meet legislative requirements. All medication charts sampled met legislative prescribing requirements. The medication charts reviewed identified that the GP had reviewed all resident’s medication three-monthly and all allergies were noted. All clinical staff who administer medications has been assessed for competency on an annual basis. Education around safe medication administration has been provided. Staff were observed to be safely administering medications. Registered nurses interviewed could describe their role regarding medication administration. The service currently uses robotic packed medications. All medications are checked on delivery against the medication chart and any discrepancies are fed back to the supplying pharmacy. The standing orders in use comply with the Standing Orders Guidelines 2016. There were three rest home residents self-medicating on the day of audit and all required documentation had been completed as sighted. The medication fridge temperature is recorded regularly and these are within acceptable ranges. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA | All meals at Cardrona are prepared and cooked on-site. There is a food services manual in place to guide staff. The food service menu was last audited by a dietitian in December 2016. There is a four-weekly seasonal menu. The cook receives dietary information for new residents and is notified of any dietary changes, weight loss or other dietary requirements by the RN. The cook is aware of any residents with weight loss and provides non-prescribed high protein supplements as instructed by the RN. Food allergies and dislikes are listed in the kitchen. Special diets such as diabetic desserts, vegetarian, pureed and alternative choices for dislikes are accommodated. Cultural and religious food preferences are met. The cook meets with residents during meal times, observes and receives verbal feedback on the menu. The cook has strong links with the RN team where she monitors resident’s meal consumption, records food wastage and reports to the RN about those residents of concern. Meals are plated and served from the kitchen to the rest home and hospital residents in the dining room. A tray service is available for those residents who wish to have their meals in their rooms. Staff were observed assisting residents with their meals and drinks. The two freezers and four fridges’ temperatures are checked daily with evidence of corrective actions taken as needed (recordings sighted). End cooked food temperatures are recorded daily. Dry goods are stored adequately. Chemicals are stored safely. Cleaning schedules are maintained. The dishwasher is checked regularly by the chemical supplier. All staff who work in the kitchen have completed their food safety course. There are specialised crockery, plates, mugs and utensils to promote resident independence with meals. Residents have the opportunity to provide feedback on the menu and food services through the resident meeting and resident surveys. Residents and family members interviewed were very satisfied with the food service provided.  |
| Standard 1.3.2: Declining Referral/Entry To Services 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.  | FA | The service records the reasons for declining service entry to residents should this occur and communicates this decision to residents/family/whānau and the referring agency. Anyone declined entry is referred back to the referring agency for appropriate placement and advice.  |
| Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative, where appropriate. Files sampled contained appropriate assessment tools that were completed and assessments that were reviewed at least six-monthly or when there was a change to a resident’s health condition. The interRAI assessment tool is implemented. InterRAI assessments have been completed for all residents. Care plans sampled were developed on the basis of these assessments. |
| Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | The long-term care plans reviewed described the support required to meet the resident’s goals and needs. The care plans sampled identified allied health involvement. The interRAI assessment process informs the development of the resident’s care plan. Residents and their family/whānau interviewed reported that they are involved in the care planning and review process. The care plans are person centred and includes physical, spiritual, psychosocial and social needs. Short-term care plans are in use for changes in health status. Staff interviewed reported they found the plans easy to follow. |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | RNs and caregivers 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 (e.g., to the district nurse [hospice nurse] or the mental health nurses). If external medical advice is required, this will be actioned by the GP. Staff have access to sufficient medical and dressing supplies. 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 as needed and this could be described. Palliative care support is available through the hospice and palliative nurse’s visit by referral or request.Wound assessment, monitoring, wound management plans and evaluations (with appropriate timeframes) are in place for residents with wounds (five skin tears, one chronic wound and three skin lesions). There were no pressure injuries at time of audit. The RNs have access to specialist nursing wound care management advice through the district nursing service and DHB wound care nurse specialist. Resident weight is recorded on admission and monitored monthly. The RNs and the cook work collaboratively to manage resident healthy weights. GP notification, dietitian referral or speech language referral for swallowing difficulties are actioned as appropriate. Interviews with RNs and caregivers demonstrated an understanding of the individualised needs of residents. Care plan interventions document interventions in sufficient detail to meet the residents’ needs. |
| Standard 1.3.7: Planned ActivitiesWhere 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 | A diversional therapist (DT) and one activity coordinator are employed for twenty hours per week to operate the activities programmes for all residents. The programme operates five days a 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 DT in consultation with the resident, families and RNs. The activity programme is driven by resident choice and planned monthly. Each resident is free to choose whether they wish to participate in the group activities programme or their own planned personal programme. Participation is monitored and documented. The DT networks with other providers and there are strong links with community. Rest home and hospital residents join together for the activity programme which is designed to meet the recreational needs of all residents. Young people with disabilities are able to participate in a range of activities to support their interests, hobbies and life-long goals. Group activities reflect ordinary patterns of life and include at least weekly planned visits to the community. One-on-one time is spent with residents who choose not to participate or unable to join in the activity programme. All long-term resident files sampled have a recent activity plan within the care plan and this is appraised at least six-monthly when the care plan is evaluated or when there is a significant change.Residents and relatives interviewed are satisfied with the current activity programme and the one-on-one companionship provided to the residents. The service conducts annual resident satisfaction surveys. The survey measures all areas of service delivery including activities. There have been improvements noted in the activities area measured in the latest resident satisfaction survey. The residents who indicated they were very satisfied with the activity service provided, increased from 79% in 2015 to 88% in 2016.A new exercise class and inter-facility bowling competition has been introduced and has become part of the ongoing activities programme. One resident is supported to maintain their art interest and art supplies are provided for them to continue. Some residents are supported to keep up attendance at activities of their choice in the community. Residents choose their own activities: six residents recently attended a harvest festival market day with residents making items (soap, lavender bags and other crafts) to sell; a sausage sizzle was held; and residents participated in games and local community, staff and families were involved. Staff interviewed described an increase in resident engagement and satisfaction during the activities that are offered.All residents and relatives interviewed on the day of audit confirmed their satisfaction with the activities and the one-on-one companionship provided to the residents |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Files sampled demonstrated that the long-term care plan has been evaluated against current goals. There was at least a three-monthly review by the GP. Reassessments have been completed using interRAI LTCF and other relevant assessment tools for residents who have had a significant change in health status. 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. 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 RNs initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs. Referrals and options for care were discussed with the family, as evidenced in medical notes. The service provided examples of where a resident’s condition had changed and the resident was reassessed for a higher or a different level of care. |
| 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 hazardous substances, generated during service delivery. | 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. |
| Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The building has a current building warrant of fitness which expires on 9 December 2017. There is a maintenance person employed part-time to address the reactive and planned maintenance programme. All reactive maintenance had been completed. All medical and electrical equipment was recently serviced and/or calibrated. Hot water temperatures are monitored and managed within 43-45 degrees Celsius. The facility has sufficient space for residents to mobilise using mobility aids. External areas are well maintained. Residents have access to safely designed external areas that have shade. Staff stated they had sufficient equipment (including personal equipment to support individual needs) to safely deliver the cares as outlined in the resident care plans for all people receiving services. The upgrade of the downstairs wing has been completed they have been working through the rooms systematically as they have become free to repaint/decorate. This includes ensuring double rooms have appropriate privacy equipment and storage appropriate for infection control |
| Standard 1.4.3: Toilet, Shower, And Bathing FacilitiesConsumers 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. | FA | There are an adequate number of toilets and shower/bathing areas for residents and separate toilets for staff and visitors. Some bedrooms have shared ensuites and other residents share communal toilets and showers close to their rooms. Residents interviewed confirmed their privacy is assured when staff are providing assistance with personal cares.  |
| Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.  | FA | There are six double rooms within the facility. All other bedrooms are single. In the double rooms, there are privacy curtains. In the lower level, there are twelve single rooms that share an ensuite (six in total) between two rooms. All resident’s 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.  |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And DiningConsumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | There are several lounges and a large dining area. The lounges and dining room are accessible and accommodate the equipment required for the residents and includes places where young persons can find privacy within communal spaces. The lounges and dining areas are large enough to cater for activities. Residents are able to move freely through and around these areas and furniture are placed to facilitate this. Residents were seen to be moving freely both with and without assistance throughout the audit. |
| Standard 1.4.6: Cleaning And Laundry ServicesConsumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | All laundry and cleaning is completed on-site by dedicated staff. 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 interviewed were satisfied with the standard of cleanliness and the laundry services provided. |
| Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations. | FA | Emergency and disaster policies and procedures and a civil defence plan are documented for the service. Fire drills occur every six months at a minimum. The orientation programme and mandatory education and training programme include fire, civil defence and security training. Staff interviewed confirmed their understanding of emergency procedures. Required fire equipment was sighted on the day of audit. Fire equipment has been checked within required timeframes. There are adequate supplies available in the event of a civil defence emergency including food, water and blankets. A gas barbeque is available. A call bell system is in place. Residents were observed in their rooms with their call bell alarms in close proximity. The registered nurses and general manager all have current first aid certificates, ensuring there is a minimum of one staff member available twenty-four hours a day, seven days a week with a current first aid/CPR certificate. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | General living areas and all resident rooms are appropriately heated and ventilated. All rooms have external windows that open allowing plenty of natural sunlight.  |
| Standard 3.1: Infection control managementThere 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.  | FA | Cardrona Rest Home 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. The clinical operations manager/registered nurse is the designated infection control coordinator with support from all staff as members of the infection control team. Infection control is discussed at all staff meetings. Minutes are available for staff. Spot infection control audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The infection control programme has been reviewed annually. |
| Standard 3.2: Implementing the infection control programmeThere are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The clinical operations manager 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 coordinator and IC team (comprising all staff) have good external support from the local laboratory infection control team and IC nurse specialist at the DHB, we also subscribe to an external advisory service (Bug Control). 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.  |
| Standard 3.3: Policies and proceduresDocumented policies and procedures for the prevention and control of infection reflect current 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. | FA | There are 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.  |
| 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 education in infection control as part of her post-graduate studies and has also completed online 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: SurveillanceSurveillance 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 Cardona’s infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. The service benchmarks infection control data with the other facility in the business. 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 all staff meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the clinical operations manager/registered nurse. There have been no outbreaks since the last audit.  |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | There are policies and procedures around restraints and enablers. One hospital level resident was using bedrails as a restraint. Three enablers (bedsides) were in use for two hospital level residents and one rest home resident. An assessment was completed and written consent was provided by the resident for the use of these enablers. Staff interviews confirmed their understanding of the differences between a restraint and an enabler.Staff receive regular training around restraint minimisation that begins during their orientation to the service. A restraint competency questionnaire is completed by staff each year. |
| Standard 2.2.1: Restraint approval and processesServices 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.  | FA | The restraint coordinator is the clinical operations manager/registered nurse. Restraint minimisation policies and procedures describe approved restraints. Restraint use is discussed in the monthly staff meetings.  |
| Standard 2.2.2: AssessmentServices shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | The restraint coordinator is responsible for assessing a resident’s need for restraint. Restraint assessments are based on information in the resident’s care plan, discussions with the resident and family and observations by staff. Assessment tools are in place for restraint use. There was one resident using a restraint at time of audit and this resident’s file was reviewed. The resident using restraint had a restraint assessment and informed consent completed for restraint use. The restraint assessment addressed risks associated with restraint use. |
| Standard 2.2.3: Safe Restraint UseServices use restraint safely | FA | A restraint register is being implemented. The register identifies the residents that are using a restraint or an enabler. All residents using a restraint or an enabler were included on the register. The restraint assessment reviewed identified that restraint is being used only as a last resort. The restraint assessment process includes determining the frequency of monitoring while restraint is in use. Restraint use was linked to the residents’ care plan and interventions to manage the associated risks were documented. Restraint policy indicates that all residents are monitored two-hourly at a minimum. Care staff had been updated on restraint procedures and documentation requirements and take responsibility to ensure restraint monitoring is correctly documented. Monitoring forms for the file reviewed were completed and included when the restraint was put on and when it was taken off.  |
| Standard 2.2.4: EvaluationServices evaluate all episodes of restraint. | FA | Restraint evaluations take place six-monthly in conjunction with the care plan reviews. Restraint use is also discussed in the monthly staff meetings. This was confirmed in the staff meeting minutes. |
| Standard 2.2.5: Restraint Monitoring and Quality ReviewServices demonstrate the monitoring and quality review of their use of restraint. | FA | The restraint minimisation programme is discussed and regularly reviewed by the clinical operations manager/restraint coordinator. The reviews include identifying trends in restraint use, reviewing restraint minimisation policies and procedures and reviewing the staff education and competency assessments. |

# 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.

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| No data to display |

# 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.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| Criterion 1.1.8.1The service provides an environment that encourages good practice, which should include evidence-based practice. | CI | The service has implemented a programme of regular engagement with the residents and families to ensure the services provided meet the needs of the residents. The clinical operations manager/registered nurse, contacts each family at least once a month to give them an update on their family members progress and the residents are encouraged to raise any concerns they have directly, or at the monthly resident meetings. The families, residents and staff interviewed reported a family like atmosphere with a strong sense of team, where the resident comes first. The resident satisfaction survey results demonstrate a high level of satisfaction with the service.  | The service conducts annual resident satisfaction surveys. The survey measures all areas of service delivery (privacy and dignity, medical assistance cleaning services, food services, activities, laundry, safety and security, gardening). There have been improvements noted across all areas measured in the latest resident satisfaction survey. The residents who indicated they were very satisfied overall with the service provided, increased from 59% in 2015 to 83.5% in 2016. The residents interviewed advised that staff were very caring and responsive, and any matter they raised was promptly dealt with. They appreciated the opportunity to have a specific agenda item at the resident meetings, and the ability to discuss as a group directly with the managers and cook, any matters of concern to them or ideas for improvements. The residents advised that the managers and staff acted very quickly to address any areas of concern and were always very approachable. The service has changed the GP contract to have a single GP providing service with the intention to improve continuity of care. This resulted in an increase in resident satisfaction with the medical service from 45% in 2015 to 70% in 2016. The service encourages and supports the staff to be resident focused and workflows and tasks are organised around resident needs. For example, the laundry staff will assist the care staff to make beds and the kitchen staff communicate with the registered nurses on the resident’s food intake daily. The food service is very responsive to resident’s requests for favourite meals, such as fish and chips, and the resident’s satisfaction with the food service has gone from 50% in 2015 to 71% in 2016. The service has also completed a number of improvements including the installation of Wifi, which is freely available for the residents to use and the introduction of a user friendly online billing facility that the families and residents interviewed stated this made things easier for them. The care staff interviewed stated they had time to spend with the residents to do extra things with the residents and advised that the general manger and clinical operations manager spent generous amounts of time engaging with the residents and their families. The resident’s satisfaction with the assistance provided, increased from 59% in 2015 to 79% in 2016.  |
| Criterion 1.3.13.1Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group. | CI | The service conducts annual resident satisfaction surveys. The survey measures all areas of service delivery including food services. There have been improvements noted across the food service measured in the latest resident satisfaction survey. The residents and families interviewed advised that staff were very responsive and they appreciated the opportunity to discuss as a group directly with the managers, nurses and cook, any matters of concern to them or ideas for improvements. There was increased availability to snack foods. Residents advised they enjoyed the fresh home baking every day. The cook knew the residents likes and dislikes and sought feedback daily from residents at mealtimes and alternatives for any dislikes were provided at the time. Weight management plans were implemented earlier and were evident for all residents at risks of weight loss.  | In May 2016, the service identified an area to improve on maintaining resident healthy weight. The service implemented a process which included closer teamwork with observation of residents eating, monitoring and recording of food wastage. There were strong links forged with cook and RN team, with the cook advising the RNs on a regular basis or as required about resident food consumption at meal times.The outcome of the project has resulted in 9 out of 17 residents with actual weight gain; 5 out of 17 resident weights remained stable and 3 out of 17 residents with weight loss, 2 residents of whom were identified as palliative and 1 resident identified with intentional weight loss. The staff interviewed reported a strong team emphasis, where maintaining the resident's healthy status is at the forefront of their focus. The resident satisfaction survey results demonstrate a high level of satisfaction with the serviceThe service encourages and supports staff to be resident focused and workflows and tasks are organised around resident needs. The cook has made sure she is available at mealtimes to observe residents dining. The kitchen staff communicate with the registered nurses on the resident’s food intake daily. The food service is very responsive to resident’s requests for favourite meals (such as fish and chips), exchanges for any dislikes and the resident’s satisfaction with the food service has gone from 50% in 2015 to 71% in 2016.Staff interviewed describe the positive impact on the resident's health status since the increased team approach with monitoring and management of resident’s food intake.  |

End of the report.