

CHT Healthcare Trust - St Christophers

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](#).

The specifics of this audit included:

Legal entity:	CHT Healthcare Trust
Premises audited:	St Christophers 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: 31 August 2017 End date: 31 August 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:	46

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

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

General overview of the audit

St Christopher's Rest Home and Hospital is owned and operated by CHT and cares for up to 46 residents requiring rest home and hospital level care, with full occupancy on day of the audit.

The manager has over nine years aged care experience and has been in her current position since the previous audit. The clinical coordinator has many years of acute care experience and has been in aged care for two years. She has been in her current role since January 2017 and was previously working at another CHT facility. The manager reports to the area manager weekly on a variety of operational issues and participates in the monthly manager's meeting. The quality and the risk management programme is implemented, and residents, relatives and the GP interviewed spoke positively about the service provided.

This unannounced surveillance audit was conducted against a subset of the health and disability sector standards and the district health board contract. The audit process included the review of policies and procedures, the review of resident and staff files, observations and interviews with residents, family members, staff, management and the GP.

Previous audit findings around regular turns, medication documentation and trend analysis of quality data and communication of these trends have been addressed.

This surveillance audit did not identify any areas requiring improvement.

The previous continuous improvement rating around meeting nutritional needs continues.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Open disclosure principles are implemented in all aspects of service delivery. Family are informed when the resident health status changes. There is a documented process for making complaints. The complaint register is up-to-date and includes actions taken and sign-off.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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The business plan is current and includes an organisational mission statement, vision and values. The quality and risk management programme is fully implemented. Corrective actions are identified, implemented and followed, through audits and feedback from residents and staff. Resident and staff meetings have been held. Health and safety policies, systems and processes are implemented to manage the risk. Incidents and accidents are appropriately managed with reporting to staff evident in meeting minutes reviewed. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. An education and training plan is being implemented and includes in-service education and competency assessments. Registered nurse cover is provided 24 hours a day, 7 days a week.

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.

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

Registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family input and within contractual timeframes. Care plans viewed demonstrated service integration and are reviewed at least six-monthly. Resident files include medical notes by the contracted general practitioners (GP) and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines and are implemented. Registered nurses and senior healthcare assistants are responsible for the administration of medicines and complete education and medication competencies. Medication charts are reviewed three-monthly by the GP.

The activities coordinators implement the activity programme to meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings, and celebrations.

All meals are cooked on-site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The building holds a current warrant of fitness.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Enabler use is voluntary. All necessary documentation has been completed in relation to the enablers and restraint. Minimisation of restraint and enabler use are linked to the quality and risk management programme.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	1	15	0	0	0	0	0
Criteria	1	38	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](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy and procedures are being implemented, and residents and their family/whānau are provided with information on admission. The manager maintains a record of all complaints, both verbal and written, using a complaint register. Eight complaints for 2017 were reviewed. Documentation including follow-up letters and resolution were complete. Discussions with residents and relatives confirmed that they were provided with information on complaints and complaints forms. Complaints forms are in a visible location at the entrance to the facility.</p> <p>Six residents (two rest home and four hospital) and three families (hospital level care) interviewed, were aware of the complaints process and to whom they should direct complaints. There is evidence of lodged complaints being discussed in staff and quality meetings. Nine staff (five healthcare assistants, one cook, one activities coordinator, two registered nurses) were interviewed and they were able to describe the process around reporting complaints.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with</p>	FA	<p>Ten resident-related incident forms were reviewed for July – August 2017. All incident forms documented that family had been informed. Relatives (three hospital level care) interviewed, stated that they are kept informed when their family member’s health status changes.</p> <p>Resident meetings occur where a variety of resident issues are discussed and resolution is documented.</p> <p>Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident</p>

<p>consumers and provide an environment conducive to effective communication.</p>		<p>should they wish to do so. 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.</p> <p>There is an interpreter policy and the manager stated that interpreter services can be accessed if required. There are no residents who currently require an interpreter. Families are encouraged to visit. Staff interviewed stated that they all try to learn a few words in another language so they can welcome residents in their first language.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>St Christopher's Hospital and Rest Home is owned and operated by CHT. The service provides rest home and hospital level care for up to 46 residents. All beds are dual-purpose.</p> <p>On the day of the audit, there were six rest home and 40 hospital level residents. One resident was under interim care and one resident was under the long-term chronic health conditions contract (both hospital level care). All other residents were under the ARC contract.</p> <p>The manager has over nine years aged care experience and she has been in her current position since the previous audit. The clinical coordinator has many years of acute care experience and has been in aged care for two years. She has been in her current role since January 2017 and previously was working at another CHT facility. The manager reports to the CHT area manager weekly on a variety of operational issues and participates in the monthly managers meeting.</p> <p>CHT has an overall business/strategic plan, philosophy of care and mission statement. St Christopher's has an annual facility-specific business plan, which links to the organisation's strategic plan. The St Christopher's goals are reviewed annually.</p> <p>The manager and clinical coordinator both have completed more than eight hours of professional development in the past 12 months.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects</p>	<p>FA</p>	<p>The quality and risk management programme is implemented. Interviews with the area manager, the manager and staff, confirmed an understanding of the quality activities undertaken at CHT St Christopher's.</p> <p>Data is collected on complaints, incidents/accidents, health and safety, clinical documentation, infection control and restraint use. The internal audit schedule for 2017 to date has been completed. Areas of non-compliance identified in audits have been actioned for improvement. The quality data is analysed, trend identified and reported to the staff through staff meetings, memos and during handovers. Staff/quality/health and safety and registered nurses' meetings minutes evidenced discussions around quality data including audit results, complaints, infection control data, health and safety issues, incidents and accidents, restraint minimisation, training and other clinical data including falls, medication errors, wounds, pressure injury, skin tears and challenging behaviours. The previous</p>

<p>continuous quality improvement principles.</p>		<p>shortfall has now been addressed.</p> <p>Policies and procedures are regularly reviewed and align with residents' admission documents and clinical, nursing social care requirements. Health and safety policies and procedures were updated and include current legislative changes. One of the registered nurses is the identified health and safety coordinator and is supported by the maintenance person and health and safety committee. Staff and contractors are orientated to health and safety issues, and all staff and the health and safety team are responsible for identifying and reporting hazards. Any new hazards are either eliminated or added to the regularly reviewed hazard register. Health and safety meetings occur monthly and include discussion around health and safety data, hazards and environmental safety. Required corrective actions and follow-up were completed and signed off. These were evidenced in the meeting minutes.</p> <p>Falls prevention strategies for individual residents such as sensor mats, low beds, landing mats and intentional rounding are implemented and were described by staff interviewed. Hip protectors are used to prevent injuries from falls.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Incident and accidents forms are completed by all staff, and required follow-up is initially completed by the registered nurse on duty. The manager and clinical coordinator investigate incident and accidents to identify a quality improvement opportunity. Incident/accident data is linked to the quality and risk management programme and outcomes are communicated to staff.</p> <p>A sample of ten incident and accident forms for the July – August 2017 period were reviewed. All incident forms had reflected a clinical assessment and follow-up by a registered nurse immediately after the incident. These include two wound dressings, three falls assessments and falls checklists and three neuro observation recordings. The other two incidents were near miss reporting so no immediate follow-up was required. All incident and accident forms were signed off by the clinical manager or the manager.</p> <p>Residents care plan evaluations include falls, behaviour and wound data from incident and accidents. New interventions were included in the residents' long-term care plans or short-term care plans following incident and accidents if risks were identified.</p> <p>The manager and the clinical coordinator are aware of their requirement to notify relevant authorities in relation to essential notifications. Since the last audit, there have been no uncontrollable events to reported HealthCERT, the coroner, police or the DHB.</p>
<p>Standard 1.2.7: Human Resource Management</p>	<p>FA</p>	<p>Human resources policies include recruitment, selection, orientation and staff training and development. Six staff files – two registered nurses, one clinical coordinator, one activities coordinator and two healthcare assistants were reviewed. All files reviewed evidenced implementation of the recruitment process, employment contracts,</p>

<p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>completed orientation, and annual performance appraisals. Copies of practising certificates are kept.</p> <p>Newly appointed staff complete an orientation that was sighted in all files reviewed. Interviews with healthcare assistants described the orientation programme that includes a period of supervision. There is an implemented annual training plan, and staff training attendance records were maintained. Interview with healthcare assistants confirmed that there is access to sufficient training. Medication competencies are completed for all staff who administer medication. Resident and family interviews confirmed that staff are knowledgeable and skilled to undertake their roles.</p> <p>Registered nurses are supported to maintain their professional competency and they can access external training. CHT employs an interRAI trainer for the organisation. Currently CHT is working towards interRAI and their electronic patient management system inter-operability training for all their facilities. This training was provided by the interRAI educator to registered nurses at St Christopher's in March 2017. Five of the eight registered nurses have completed interRAI training.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The CHT staffing policy includes staff rationale and skill mix. At least one registered nurse is on-site at any one time. Activities staff works five hours a day and seven days a week. Cleaning, laundry and food services are outsourced.</p> <p>On the day of audit there were 40 hospital level care residents and six rest home care residents. Healthcare assistants roster is as follows. In the morning, six staff work 7am - 3pm and one staff works 7am -12noon. In the afternoon shift, there are three staff 3pm - 11pm, one staff 4pm - 9pm and one staff 3pm - 9pm. At night two staff 11pm -7am.</p> <p>The clinical coordinator works from 6.45am - 3.15pm. Registered nurses also work 15 minutes either end of the shift to allow handovers.</p> <p>Residents and families interviewed stated that staff are busy at certain times of the day but resident needs are met. Staff interviewed stated that they are busy but they get through their daily workload.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with</p>	<p>FA</p>	<p>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were no residents self-administering on the day of audit. There were no standing orders.</p> <p>The facility uses a robotic pack system. Medications are checked on arrival and any pharmacy errors are recorded and fed back to the supplying pharmacy. Registered nurses and senior healthcare assistants administer medications in the hospital and rest home. Staff attend annual education and have annual medication competency checks. Four registered nurses have syringe driver training completed by the hospice. The medication fridge temperature is checked weekly. Eye drops are dated once opened.</p>

<p>current legislative requirements and safe practice guidelines.</p>		<p>Staff sign for the administration of medications on the electronic system used. Twelve medication charts were reviewed (ten hospital and two rest home) and demonstrated that all medications, including 'as required' medications are bang signed for when they are administered. This is an improvement since the previous audit. Medications are reviewed at least three-monthly by the GP. There was photo identification and allergy status recorded. 'As required' medications had indications for use charted. This is an improvement since the previous audit.</p> <p>St Christopher's rest home and hospital do not store vaccines on-site.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>CI</p>	<p>The service has a contract with Compass. There are two cooks and two kitchen hands. Both cooks and one kitchenhand have current food safety certificates. The other kitchen hand who is new is currently completing their certificate. The head cook oversees the procurement of the food and management of the kitchen. There is a well-equipped kitchen and all meals are cooked on-site. Meals are transported in warming drawers and served in the dining rooms. Special equipment such as lipped plates are available. On the day of audit meals were observed to be hot and well presented. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits and food satisfaction surveys are implemented to monitor performance. Kitchen fridge and freezer temperatures were monitored and recorded weekly. Food temperatures are checked and these were all within safe limits. The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. This is reviewed six-monthly as part of the care plan review. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes were noted on a kitchen whiteboard. The four-weekly menu cycle is approved by the Compass dietitian.</p> <p>The facility is proactive regarding weight loss management. They use Health Care Trust's replenish, energy and protein (REAP) protocol. Two hospital residents' files sampled were on the REAP regime (level one and level three). The facility continued to implement the REAP regime and this continues to exceed the required standard.</p> <p>All resident/families interviewed were satisfied with the meals, although some noted they would like more ethnic food. The facility is currently investigating this.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their</p>	<p>FA</p>	<p>When a resident's condition changes the registered nurse initiates a GP consultation. Staff state that they notify family members about any changes in their relative's health status. All care plans sampled had interventions documented to meet the needs of the resident. Care plans have been updated as residents' needs changed.</p> <p>Care staff interviewed state that there are adequate clinical supplies and equipment provided including continence and wound care supplies, and these were sighted.</p> <p>Wound assessment, wound management and evaluation forms are in place for all wounds. Wound monitoring occurs as planned. There are currently four minor wounds and six pressure injuries being treated. All wounds and</p>

<p>assessed needs and desired outcomes.</p>		<p>pressure injuries have photos attached.</p> <p>The facility is proactive regarding weight loss management. Monitoring forms are in use as applicable such as positional turning, weight, vital signs and wounds. Behaviour charts are available for any residents that exhibit challenging behaviours.</p> <p>At the previous audit there was a corrective action required around turning charts not being signed at night. Two turning charts reviewed showed that record of turning and re-positioning of residents were recorded each shift and this was corresponding with interventions identified in the resident's care plan. This shortfall has now been resolved.</p> <p>Care plans include resident's choices and preferences. Management and registered nurse interviews confirmed knowledge and understanding around advance directives. The manager and the clinical coordinator reported that there are no residents with advance directives on the day of audit.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>There are two activities coordinators. One works five and a half hours daily from Monday to Friday and the other works five and a half hours daily at the weekend. On the day of audit, the activities coordinator was on leave but came in to be interviewed. On the afternoon of audit, the male residents were having a Fathers' day happy hour with poker, snacks and beer.</p> <p>There is a weekly programme in large print on noticeboards in all areas and some residents have them in their rooms. Residents have the choice of a variety of activities in which to participate, and every effort is made to ensure that activities are meaningful and tailored to residents' needs. These include exercises, brain teasers, news from the NZ Herald, music, walks outside and games. The physiotherapist runs a more extensive exercise class on a Wednesday.</p> <p>Those residents who prefer to stay in their room or who need individual attention have one-on-one visits to check if there is anything they need and to have a chat.</p> <p>There is an Anglican church service fortnightly and a Catholic service monthly. The Anglicans notify the facility when there are social events at the church as some more able residents like to attend. Some residents go to church with their families.</p> <p>There is a regular scheduled van outing. There are regular entertainers visiting the facility. Special events like birthdays, Easter, Fathers' Day, Anzac Day and the Melbourne Cup are celebrated.</p> <p>There is community input from churches and the local primary school whose students visit every Friday afternoon.</p> <p>Residents have an activity assessment completed over the first few weeks following admission that describes the residents past hobbies and present interests, career and family. Resident files reviewed identified that the comprehensive individual activity plan is based on this assessment. Activity plans are evaluated at least six-monthly</p>

		at the same time as the review of the long-term care plan.
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	The five long-term care plans reviewed had been evaluated by the registered nurses six-monthly or when changes to care occurs. Short-term care plans for short-term needs are evaluated and signed off as resolved or added to the long-term care plan as an ongoing problem. The multidisciplinary review involves the RN, GP and resident/family if they wish to attend. There is at least a three-monthly review by the GP for rest home and one monthly for hospital residents. The family members interviewed confirmed that they are informed of any changes to the care plan.
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	The facility has a current building warrant of fitness which is valid until 16 March 2018.
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	Policies and procedures document infection prevention and control surveillance methods. The surveillance data is collected and analysed monthly to identify areas for improvement or corrective action requirements. Infection control internal audits have been completed. Infection rates have been low. Trends are identified and quality initiatives are discussed at staff/quality and health and safety meetings. There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are appropriate to the complexity of service provided.
<p>Standard 2.1.1: Restraint minimisation</p>	FA	There was one resident with restraint (bed rails) and four residents with enablers. Enabler use is voluntary. All necessary documentation has been completed in relation to the enablers and the restraint. Minimisation of restraint and enabler use were discussed at the staff, quality and health and safety meetings.

Services demonstrate that the use of restraint is actively minimised.		Quality review of restraint and enabler use shows no injuries resulting use of these.
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Specific results for criterion where corrective actions are required

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

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

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

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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.3.13.2</p> <p>Consumers who have additional or modified nutritional requirements or special diets have these needs met.</p>	CI	<p>The service is active in ensuring the specific nutritional needs of residents are met, including the provision of special diets and altered texture meals. The menus have been approved by a dietitian. Weight loss is actively managed with dietitian input where required and the provision of the REAP programme.</p>	<p>The service continues to be proactive about identifying and addressing potential or actual weight loss in residents.</p> <p>This is achieved using the ‘REAP’ (replenish, energy and protein protocol). This involves identifying residents that are losing weight or are at risk of losing weight and having them assessed by a dietitian if appropriate. The kitchen is then notified (confirmed by the kitchen manager interviewed) and the residents on the programme are provided with a diet of food that is fortified with extra calories and high calorie milk desserts or similar for morning and afternoon teas and supper.</p> <p>As a result of this the service provided examples from the past year of residents whose weight has stopped declining or have increased. The two residents on the REAP programme at the time of the audit were both losing weight and are now both gaining weight.</p>

End of the report.