

Clair House Limited - Claire House Aged Care Facility

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: Clair House Limited

Premises audited: Claire House Aged Care Facility

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 8 August 2019 End date: 8 August 2019

Proposed changes to current services (if any): One additional bedroom was assessed as suitable for rest home care increasing the number of beds from 54 to 55.

Total beds occupied across all premises included in the audit on the first day of the audit: 54

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

Claire House Aged Care provides rest home care for up to 55 residents. On the day of the audit there were 54 residents. The rest home has been owner/operated for 34 years.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management, staff and the general practitioner.

The residents, relatives and general practitioner spoke highly of the care and service provided at Claire House. The service has a well-established quality system that identifies ongoing quality improvement.

The manager (owner/operator) and assistant manager are non-clinical and supported by two registered nurses experienced in aged care.

The service has maintained continuous improvement ratings around food services and reduction of respiratory tract infections.

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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Discussions with families identified that they are kept fully informed of changes in their family member's health status. Information about the complaints process is easily accessible to residents and families. Management operate an open-door policy. Complaints policies and procedures meet requirements and residents and families are aware of the complaints process.

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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Quality management processes are reflected in the businesses plans, goals, objectives and policies. A risk management programme is in place, which includes incident and accident reporting, internal audits, surveys and health and safety processes. There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. The service has an annual training schedule for in-service education that includes on-site in-service and on-line learning modules. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

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. Care plans viewed demonstrate service integration and are reviewed at least six monthly. Resident files include medical notes by the contracted general practitioners and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Senior healthcare assistants are responsible for the administration of medicines. Medication charts are reviewed three monthly by the GP.

The activities coordinator implements 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. Residents commented positively on the meals.


Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.

Standards applicable to this service fully attained.

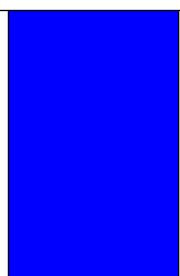
The building holds a current warrant of fitness. The new resident room is fit for purpose.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. At the time of the audit, the service had no residents using restraints or enablers. Staff have received training around restraint minimisation and management of challenging behaviours.

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.		All standards applicable to this service fully attained with some standards exceeded.
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The infection control coordinator is the senior registered nurse who oversees infection control for the service. Information obtained through surveillance is used to determine infection control activities and education needs within the facility. Staff are kept informed on infection control matters through facility meetings.

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	2	14	0	0	0	0	0
Criteria	2	39	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 service has a complaints policy that describes the management of the complaints process. The owner/manager and assistant manager operate an 'open door' policy. The manager is the privacy officer and addresses complaints/concerns in consultation with the registered nurses (RN) for clinical issues. Complaint forms are available. Information about complaints is provided on admission. Complaints process and code of rights is discussed at the monthly resident meeting and all residents have a handbook in their rooms. Six residents and three relatives interviewed confirmed they are aware of the complaints process. Healthcare assistants interviewed were able to describe the process around reporting complaints. There were 25 complaints/concerns with many raised in meeting minutes for 2018 and seven concerns received for 2019 to date. All concerns had been addressed, investigated (as appropriate) and followed-up with meetings to ensure the complainant was satisfied with the outcome. There have been no DHB or HDC complaints.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and</p>	FA	<p>There is an open disclosure policy in place. Communication with family members is recorded on the incident report forms and in the resident daily progress notes. Thirteen incident/accident forms reviewed identified that family were notified following a resident incident. Three family members interviewed stated they were well informed and involved when needed in residents care. Resident meetings are held monthly in each house and are open to families to attend. Open discussion is encouraged around the services provided (meeting minutes sighted).</p> <p>The residents and family are informed prior to entry of the scope of services and any items they have to pay that is</p>

<p>provide an environment conducive to effective communication.</p>		<p>not covered by the agreement. There are interpreter services available as required.</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>Claire House offers rest home level care for up to 55 residents. Claire House is split into three buildings. Claire House has 16 of 16 residents, Clairemont has 16 of 16 residents, Fleurmont has 18 of 18 residents and Claire Villa had four of five residents. One additional resident room was assessed in the downstairs Fleurmont building. On the day of audit there were 54 residents. There were three residents under long-term chronic health condition funding, two younger persons under MOH funding, to residents under the mental health act and one resident under the mental health funding. All other residents were under the ARCC.</p> <p>The owner/manager is non-clinical and has owned and managed the facility for 34 years. The owner/manager is supported by an assistant manager (non-clinical) who has been in the role three years and is responsible for administration, human resources, education and overseeing quality systems. The management team are supported by two RNs. One RN (35 hours per week) has been at Claire House for eight years and completing a master's degree. The other RN is 32 hours per week, one is based in Claire House and the other Fleurmont House. The workforce is stable and long serving.</p> <p>The owner/manager lives in an adjoining property and is available 24 hours a day/seven days a week if necessary. The two RNs cover the on-call.</p> <p>There is a 2019 business plan in place with goals that are regularly reviewed. Goals achieved to date include (a) developing resident-focused cares through updating the resident needs and treatment forms which detail specific residents care preferences, (b) introduction of CHOMP, an electronic food safety system that is linked to the menus, (c) addition of one resident room and continuing building plans for another three rooms and (d) implementation of on-line learning.</p> <p>The owner/manager has maintained at least eight hours annually of professional development activities related to managing a rest home. She attends the two monthly aged care consultant meetings which includes external speakers covering topics such as human resources, legislation, employment law and food safety. The manager and RN attend DHB cluster group meetings.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has</p>	<p>FA</p>	<p>A quality and risk management programme is being implemented. Quality goals were documented in the staff/quality meeting minutes. Policies and procedures are provided by an external consultant with evidence of regular reviews. Staff are made aware of any policy changes through staff meetings, evidenced in meeting minutes. There is monthly collating of quality and risk data that includes monitoring accidents and incidents, infection rates concerns and complaints, pressure injuries, survey outcomes and internal audit outcomes. Facility meetings include continuous quality improvement meeting (managers and RNs), staff meetings and combined health and</p>

<p>an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>safety/infection control meetings. There is evidence in meeting minutes of discussion around all quality data. All staff read and sign the meeting minutes.</p> <p>Internal audits regularly monitor compliance. A corrective action form is completed where areas are identified for improvement. Re-audits occur as required. Staff are kept informed regarding results via staff meetings and during staff handovers. There are annual resident satisfaction and family satisfaction surveys completed. There was a greater response in 2018 due to an on-line survey. All responses were either very satisfied or satisfied. The 2019 survey is not yet due. The service completes two monthly resident surveys of 20 residents each time for aspects of the service including code of rights/complaints/advocacy, food service and activities. Survey results are summarised, and any corrective actions were implemented and fed back to participants.</p> <p>A health and safety programme is in place, which includes reviewing incidents/accidents and managing identified hazards. The assistant manager is the health and safety officer and has completed health and safety training October 2017. There are two nominated health and safety representatives each year which (over time) gives all staff an opportunity to take on the role and be actively involved in health and safety. Health and safety meetings and environmental walk-arounds are conducted each month. There is a current hazard register.</p> <p>Falls prevention strategies include the analysis of falls events and the identification of interventions on a case-by-case basis to minimise future 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>The service collects all incident and accident information reported by staff on a paper-based system and entered into a monthly data collection form which is analysed for trends and corrective actions. Incident and accident data are reported to the monthly continuous quality improvement meeting. Fifteen resident related incident forms were reviewed for July 2019. Each event involving a resident reflected a clinical assessment and follow-up by a RN. Neurological observations had been completed for unwitnessed falls. Care staff interviewed were very knowledgeable regarding the care needs (including high falls) for all residents. Discussions with the owner/manager and assistant manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been three section 31 notifications for 2019 to date, related to absconding residents requiring police intervention.</p>
<p>Standard 1.2.7: Human Resource</p>	<p>FA</p>	<p>Human resources policies include recruitment, selection, orientation and staff training and development. Five staff files (one RN, three HCAs and one diversional therapist) reviewed, evidenced implementation of the recruitment</p>

<p>Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>process, employment contracts, completed orientation and annual performance appraisals. A register of RN and other health practitioner practising certificates is maintained.</p> <p>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 and is followed up with a two-week assessment. Staff interviewed were able to describe the orientation process and reported new staff were adequately orientated to the service.</p> <p>Monthly in-service is held at the end of the staff meetings. The 2018 annual education plan has been completed and the 2019 education plan is being implemented. The service has introduced on-line modules through an aged care consultant. The site is accessible for staff from their home. The assistant manager maintains individual records of training which includes attendance at on-site training and on-line modules. External speakers include H&D advocate, aged care consultant, hospice, pharmacist, age concern and the physiotherapist for safe manual handling. Two of two RNs have completed their interRAI training. A roving assessor is available to support care staff through Careerforce qualifications.</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 service has a documented rationale for determining staffing levels and skill mixes for safe service delivery, meeting contractual requirements. The owner/manager and assistant manager work full-time and live on the premises. There are two part-time RNs employed from Monday to Friday.</p> <p>Claire House is divided into four houses, Claire House (16 residents), Clairemont (16 residents), Fleurmont (18 residents) and Claire Villa has four residents. There was a total of 54 residents. There is one RN on duty for 35 hours Monday to Friday based in Claire House/Clairemont. There is another RN on duty for 32 hours from Monday to Friday based in Fleurmont/Claire Villa. The RNs are supported by two enrolled nurses and adequate numbers of HCAs.</p> <p>In Claire House/Clairemont there are four HCAs on duty on the morning shift (two full shift and two short shift) and two HCAs on the full afternoon shifts and two HCAs on the night shift. In Fleurmont there are two HCAs on duty on the morning for the full shift, one HCA on the afternoon shift and one on the night shift. There is an HCA on duty from 7 am to midday each day in the five-bed villa. Cover is provided from Claire house after midday to 8 am.</p> <p>There are designated staff for activities, food services and cleaning/laundry. Staff (interviewed) reported that staffing levels and the skill mix were appropriate and safe. Residents and relatives interviewed advised that they felt there are sufficient staffing.</p>
<p>Standard 1.3.12: Medicine</p>	<p>FA</p>	<p>There are 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. All policies and procedures had been adhered to.</p>

<p>Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>There are no standing orders. There are no vaccines stored on site.</p> <p>The facility uses an electronic and robotic pack system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. Senior medication competent HCAs administer medications. All staff have up-to-date medication competencies and there has been medication education this year. The medication fridge temperature is checked daily. Eye drops are dated once opened.</p> <p>Staff sign for the administration of medications electronically. Ten medication charts were reviewed. 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 prescribed.</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 two cooks who cover Monday to Sunday between them. They work from 9 am to 6 pm. There are kitchenhands on each day from 8 am to 1 pm. All kitchen staff have current food safety certificates. Both cooks oversee 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 served in the dining rooms from hot boxes. Meals going to rooms on trays have covers to keep the food warm. Special equipment such as lipped plates is available.</p> <p>On the day of audit meals were observed to be hot and well-presented and residents stated that they were enjoying their meal. There is an online kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures were monitored and recorded daily. 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 are known. The four-weekly menu cycle is approved by a dietitian. All residents and family members interviewed were satisfied with the meals with positive comments on the vegetarian option available at each meal.</p> <p>The facility has purchased a computer programme which enables access to all recordings, menus and work schedules online. The CI rating has been maintained.</p> <p>The food control plan has been submitted and scheduled for verification.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and</p>	<p>FA</p>	<p>When a resident's condition changes the registered nurse initiates a GP consultation. Staff stated that they notify family members about any changes in their relative's health status and family interviewed confirmed this. 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>Resident falls are reported on accident forms and written in the progress notes. Neurological observations are</p>

<p>appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>completed for unwitnessed falls or falls where residents hit their heads. Family are notified.</p> <p>Care staff interviewed state there are adequate clinical supplies and equipment provided including continence and wound care supplies.</p> <p>Wound assessment, wound management and evaluation forms are documented, and wound monitoring occurs as planned. There are currently three wounds being treated (including the stage two pressure injury). One chronic wound has had input from a dermatologist. There is currently one stage two pressure injury.</p> <p>There are monitoring forms in use as applicable such as weight, vital signs, wounds and behaviour.</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 is an activities coordinator who works 28 hours a week plus two floating other activity staff if required. The activities coordinator attends diversional therapy study days four times a year and also attends the facility's in-services. Students from a diversional therapy course come to the facility for clinical experience and are supervised by the activity coordinator in conjunction with their tutor.</p> <p>There is a weekly programme in large print on noticeboards. Residents have the choice of a variety of activities in which to participate and every effort is made to ensure activities are meaningful and tailored to residents' needs. These include exercises, games, quizzes, arts and crafts, music and walks outside. The YPD residents participate in many of the activities available and enjoy the close proximity and access to the local shops and cafés. 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. The diversional therapy students enjoy assisting with this.</p> <p>There is an interdenominational church service every four weeks and a Catholic volunteer visits weekly to give the Catholic residents communion.</p> <p>Currently there are no van outings as the company who was assisting with this is no longer able to do so. Other avenues are being explored. There is a shopping centre close by and residents enjoy visiting this independently or with assistance from the activity coordinator.</p> <p>There are regular entertainers visiting the facility at the weekends. Special events such as birthdays, Easter, Anzac Day, and Queens's birthday are recognised and celebrated. Happy Hour is four weekly and there is always singing and dancing.</p> <p>There are four rest home cats. Pet therapy is five weekly and six dogs attend.</p> <p>One resident goes to a Māori singing group, one goes to an art class and two attend a rehabilitation gym twice weekly.</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 activity plan is based on this assessment. Activity plans are evaluated at least six monthly at the same time as the review</p>

		<p>of the long-term care plan.</p> <p>Resident meetings are held monthly and there is an annual activities satisfaction survey that evidenced satisfaction with the activity programme.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The five 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. Activities plans are in place for each of the residents and these are also evaluated six monthly. The multidisciplinary review involves the RN, GP and resident/family if they wish to attend. There are three monthly reviews by the GP for all residents. Family members interviewed confirmed that they are informed of any changes to the care plan.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The facility has a building warrant of fitness which expires 30 September 2019. Preventative and reactive maintenance occurs. One additional room in downstairs Fleurmont house was assessed as suitable for rest home care. The new room is spacious and has an ensuite. There is sufficient room in the ensuite for a shower chair if required. The resident has a pendent bell which can be worn in the shower.</p>
<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>	CI	<p>Systems in place are appropriate to the size and complexity of the facility. There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place appropriate to the complexity of service provided. The surveillance data is collected and analysed monthly to identify areas for improvement or corrective action requirements. Trends are identified and quality initiatives are discussed at the combined health and safety/infection control meetings and facility meetings. The service continues to benchmark against the previous years to identify trends or any areas for improvement. The service has been successful in maintaining urinary tract infections below the benchmark since the previous audit. The service intervenes early with alternative therapies (trailing) for any resident with flu-like signs and symptoms and has reduced the need for antibiotics. The GP reviews antibiotic use at least three monthly with the medication review. Systems in place are appropriate to the size and complexity of the facility.</p> <p>There has been one outbreak of confirmed norovirus in March 2019. Notification to public health and case logs were sighted. The outbreak was well managed with plentiful resources and contained within one house.</p>

<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. There were no residents using restraints or enablers at the time of audit. Staff training around restraint minimisation and management of challenging behaviours last occurred in September 2018.</p>

Specific results for criterion where corrective actions are required

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

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

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

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
Criterion 1.3.13.1 Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.	CI	The service has continued to provide a vegetarian option at all meals. Resident feedback and survey result evidence demonstrates residents are very satisfied with the meals provided.	Vegetarian options remain available at each meal and are written on the menu boards in each house. Residents interviewed commented on the flavour and presentation of vegetarian meals. Food services and meals provided are discussed at each resident meeting. Resident survey evidences they are very satisfied with the meals including the vegetarian option. Twenty residents per month are surveyed against all aspects of service including food satisfaction. Survey results are summarised, and any corrective actions implemented and fed back to participants at their resident meetings. There have been no concerns or complaints regarding meals since the introduction of vegetarian meals. Residents who prefer vegetarian meals (interviewed and surveyed indicates a 100% satisfaction with their meals.
Criterion 3.5.7 Results of surveillance, conclusions, and	CI	The service is trialling in consultation with the GP, early intervention with alternative for	Influenza vaccine uptake has increased with 90%+ residents and 80% staff. Staff education and prompt and early reporting of cold and flu-like signs and symptoms ensure the RNs are notified and household remedies initiated immediately to prevent worsening symptoms and the spread of infection. The action plan includes maintaining resident hydration status and offering extra fluids, lemon and honey drinks, throat lozenges and paracetamol for comfort.

<p>specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.</p>		<p>residents with chest and cold signs and symptoms. The service has been successful to date with reducing the number of residents requiring antibiotics in comparison with 2018 numbers.</p>	<p>The GP is notified, and the residents closely monitored. In May 2019 there were 13 residents with cold and flu-like symptoms that were managed with early intervention with alternative therapies. Two residents required treatment with antibiotics compared with 4 residents in May 2018. For June, one resident has been treated with antibiotics compared with five in June 2018. There were no chest infections treated with antibiotics in July 2019 compared with 12 in July 2018. The service has been successful to date in reducing chest infections. The trial will be formally evaluated at the end of the winter months.</p>
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End of the report.