# Strathallan Healthcare Limited - Strathallan Lifecare

## 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:** Strathallan Healthcare Limited

**Premises audited:** Strathallan Lifecare

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

**Dates of audit:** Start date: 23 November 2015 End date: 24 November 2015

**Proposed changes to current services (if any):** This audit has assessed that the service is able to provide rest home level care for up to 10 residents in the two serviced apartment wings.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 78

# 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

Strathallan Life Care Village is part of the Hurst Lifecare group. The service is certified to provide rest home, hospital and dementia level care for up to 88 residents including 10 in serviced apartments that were verified as appropriate to provide rest home level care as part of this audit. On the day of the audit there were 78 residents.

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 resident’s and staff files, observations and interviews with residents, relatives, staff and management.

Strathallan is managed by a general manager who is appropriately qualified and experienced. There are quality systems and processes being implemented. Feedback from residents and relatives is positive about the care and services provided. An induction and in-service training programme is provided.

The service exceeds the required standard around response to individual needs and independence, the spark of life activities programme and the external environment in the dementia unit. Improvement is required around aspects of registered nursing follow up, and wound evaluations.

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

Staff demonstrate an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work duties and caring for the residents. Residents receive services in a manner that considers their dignity, privacy and independence. Written information regarding consumers’ rights is provided to residents and families. Cultural diversity is celebrated. Evidence-based practice is evident, promoting and encouraging good practice. There is evidence that residents and family are kept informed. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service.

## 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. |

Services are planned, coordinated, and are appropriate to the needs of the residents. A general manager and assistant manager (both registered nurses) are responsible for the day-to-day operations of the facility and are supported by an organisational quality advisor and two care managers. Goals are documented for the service with evidence of annual reviews. A risk management programme is in place, which includes managing adverse events and health and safety processes.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. A comprehensive orientation programme is in place for new staff. Ongoing education and training for staff is in place.

Registered nursing cover is provided 24 hours a day, seven days a week.

The residents’ files are appropriate to the service type and are compliant with all legislative requirements.

## Continuum of service delivery

|  |  |  |
| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Some standards applicable to this service partially attained and of low risk. |

An information pack is made available to the resident and family/whānau prior to entry or on admission. Assessments (including InterRAI) and support plans reviewed were developed and implemented within the required timeframes. The residents' needs, objectives/goals have been identified in the long-term support plans and these have been reviewed at least six monthly. Resident files are integrated and include notes by the GP and allied health professionals.   
The activity programme is resident-focused and provides group and individual activities planned around everyday activities.

There are medicine management policies and procedures in place. Medication is managed using a computerised medication management system with current guidelines. The medication charts meet legislative prescribing requirements and are reviewed by the GP three monthly.

Meals are cooked on site and food service staff are aware of resident’s likes/dislikes and alternative choices are offered.

## 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 building warrant of fitness and maintenance is carried out. All rooms are single and personalised. There is adequate room for the safe delivery of care within the resident’s rooms. Residents can freely access communal areas using mobility aids. There are communal dining areas, lounges and recreational areas plus small seating areas in all areas. Outdoor areas are safe and accessible for the residents. The dementia unit is safe and secure including the garden there is adequate equipment for the safe delivery of care. All equipment is well maintained on a planned schedule. The cleaning service maintains a tidy, clean environment. There are emergency policies and procedures in place to guide staff should an emergency or civil defence event occur. Staff practise fire drills six monthly.

The apartments to be used for rest home level care are in two areas on the ground floor. Each has a bedroom, lounge, kitchenette and bathroom. Call bells are available in bedrooms, lounges and bathrooms.

## 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. |

Enablers are voluntary and the least restrictive option. There were three hospital residents with restraints and two residents who required enablers during the audit. Appropriate policies and staff training are in place around restraint and enabler use.

## 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. Documented policies and procedures are in place for the prevention and control of infection and reflect current accepted good practice and legislative requirements. Infection control education is provided to all service providers as part of their orientation and also as part of the on-going in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Results of surveillance are acted upon, evaluated and reported to relevant personnel.

## 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 | 47 | 0 | 1 | 0 | 0 | 0 |
| **Criteria** | 3 | 97 | 0 | 1 | 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 Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) poster is displayed in a visible location. A policy relating to the Code is implemented and staff can describe how the Code is incorporated in their everyday delivery of care. Staff receive training about the Code during their induction to the service, which continues through in-service education and training. Interviews with nine caregivers (including three who work in the dementia unit), five registered nurses including two care managers and the staff educator, two diversional therapists, one activities coordinator, the assistant manager and the general manager reflected their understanding of the key principles of the Code. |
| Standard 1.1.10: Informed Consent  Consumers 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. Written consents are included within the admission agreement and are signed by the resident or their EPOA. Advanced directives are signed for separately. There is evidence of discussion with family when the GP completed a clinically indicated not for resuscitation order. Caregivers and registered nurses interviewed confirmed verbal consent is obtained when delivering care. Discussion with family members identified that the service actively involves them in decisions that affect their relative’s lives. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Information on advocacy services through the HDC Office is included in the resident information pack that is provided to residents and their family on admission. Pamphlets on advocacy services are available at the entrance to the facility. Interviews with the residents and relatives confirmed their understanding of the availability of advocacy (support) services. Staff receive education and training on the role of advocacy services. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | Residents may have visitors of their choice at any time. The service encourages the residents to maintain relationships with their family, friends, and community groups by encouraging their attendance at functions and events, and providing assistance to ensure that they are able to participate in as much as they can safely and desire to do. This includes resident’s visits to the local shops, visiting the library and attending community celebrations. |
| 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 relatives at entry to the service. A record of all complaints, both verbal and written is maintained by the facility manager using a complaints’ register. Documentation including follow up letters and resolution demonstrates that complaints are being managed in accordance with guidelines set forth by the Health and Disability Commissioner.  Discussions with the residents and relatives confirmed they were provided with information on complaints and complaints forms. Complaints forms and a suggestions box are in a visible location at the entrance to the facility. Complaints received in 2015 were reviewed with evidence of appropriate follow-up actions taken. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | Details relating to the Code are included in the resident information pack that is provided to new residents and their family. This information is also available at reception. The care managers, assistant manager or registered nurses (RN) discusses aspects of the Code with residents and their family on admission.  Discussions relating to the Code are held during the monthly rest home resident/family meetings. All 14 residents (seven rest home level and seven hospital level) and eight relatives (two rest home level, two dementia level and four hospital level) interviewed report that the residents’ rights are being upheld by the service. Interviews with residents and family also confirmed their understanding of the Code and its application to aged residential care. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | CI | The service ensures that the residents’ rights to privacy and dignity are recognised and respected at all times. The residents’ personal belongings are used to decorate their rooms. All rooms are currently single occupancy. Discussions of a private nature are held in the residents’ rooms. The caregivers interviewed report 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 report that they encourage the residents' independence by encouraging them to be as active as possible. All of the residents interviewed confirmed that their privacy is being respected.  Guidelines on abuse and neglect are documented in policy. Staff receive education and training on abuse and neglect. Any suspected instances of abuse or neglect are dealt with in a prompt manner by the management team.  The service has exceeded the standard around encouraging resident’s independence. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Maori are valued and fostered within the service. They value and encourage active participation and input of the family/whanau in the day-to-day care of the resident. Cultural needs were identified in the care plan of the Maori resident.  Maori consultation is available through the documented Iwi links. Staff receive education on cultural awareness during their induction to the service and as a regular in-service topic. All caregivers interviewed were aware of the importance of whanau in the delivery of care for Maori residents. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | The service identifies the residents’ personal needs and values from the time of admission. This is achieved with the resident, family and/or their representative. Cultural values and beliefs are discussed and incorporated into the residents’ care plans. All residents and relatives 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: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | A staff code of conduct is discussed during the new employee’s induction to the service and is signed by the new employee. Professional boundaries are defined in job descriptions. Interviews with caregivers 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 Practice  Consumers receive services of an appropriate standard. | FA | Evidence-based practice is evident, promoting and encouraging good practice. Registered nursing staff are available seven days a week, 24 hours a day. Residents identified as stable are reviewed by the general practitioner (GP) every three months with more frequent visits for those residents whose condition is not deemed stable.  The service receives support from the District Health Board which includes visits from the mental health team and nurse specialist’s visits. Physiotherapy services are provided on site, a minimum of four hours per week. There is a regular in-service education and training programme for staff. The service has links with the local community and encourages residents to remain independent.  The GPs interviewed is satisfied with the level of care that is being provided.  The service has a number of examples of good practice including the breakfast club, subway lunches and hospital dining experiences (link 1.1.3.6); the implementation of the Spark of Life programme (link 1.3.7.1), the improvements to the dementia’s garden (link 1.4.2), maintaining tertiary level in the ACC workplace safety audit in March 2015, the hosting of nursing students. Seventy per cent of registered nurses are interRAI trained and the site introduced the medimap medication system in October 2015. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Policies and procedures relating to accident/incidents, complaints and open disclosure policy alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs.  Evidence of communication with family/whanau is recorded on the family/whanau communication record, which is held in each resident’s file. A three monthly summary is sent to each family informing them of the resident’s progress and special events they have been involved in. Family complete a form determining which circumstances they would like to be notified of. Accident/incident forms have a section to indicate if next of kin have been informed (or not) of an accident/incident. Fifteen accident/incident forms reviewed identified family are kept informed to the level they request. Relatives interviewed stated that they are kept informed when their family member’s health status changes.  An interpreter policy and contact details of available interpreters is available. Interpreter services are used where indicated. The information pack is available in large print and is read to residents who require assistance.  Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entry. The residents and family are informed prior to entry of the scope of services and any items they have to pay that are not covered by the agreement. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Strathallan Life Care Village is a Hurst Lifecare Group residential care facility. The service provides care for up to 88 residents at hospital, rest home, and dementia level of care including up to ten rest home level residents in serviced apartments which have been verified as suitable during this audit. On the day of the audit there were 38 hospital level residents, 20 residents in the dementia unit and 19 rest home level residents including one resident in a serviced apartment. There are 19 dual purpose beds in the ‘rest home’ wing. All residents were under the Age Related Care contract.  A vision, mission statement and objectives are in place. Annual goals for the facility have been determined, which link to the overarching Hurst Lifecare Group strategic plan.  The general manager is a registered nurse with a current practising certificate who has been in the role for 15 years. She is supported by an assistant manager (RN) who has worked at the service for 15 years and in the current role for 18 months and two care managers (registered nurses), one overseeing the hospital wing and the other the rest home wing (containing dual purpose beds) and the dementia unit.  The general manager and assistant manager have maintained over eight hours annually of professional development activities related to managing an aged care service. |
| 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 | The general manager is supported by an assistant manager/registered nurse (RN) who is employed full time and steps in when the manager is absent. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | A quality and risk management programme in place. Interviews with the managers and staff reflect 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. A document control system is in place. Policies are regularly reviewed and have been updated to include interRAI requirements. New policies or changes to policy are communicated to staff. The monthly monitoring, collation and evaluation of quality and risk data allows analysis and quality data is benchmarked with the organisations other three facilities. An annual internal audit schedule was sighted for the service with evidence of internal audits occurring as per the audit schedule. Corrective action plans are developed when service shortfalls are identified.  Quality and risk data, including trends in data and benchmarked results are conveyed to staff through staff newsletters.  Falls prevention strategies are in place. A health and safety system is in place. Hazard identification forms and a hazard register are in place. The organisation holds tertiary accreditation by ACC for their workplace safety management programme. |
| 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 | Individual incidents and accidents are reported, investigated with immediate action noted and any follow up action(s) required. Incident/accident data is linked to the organisation's quality and risk management programme and is used for comparative purposes. Fifteen accident/incident forms were reviewed. Each event involving a resident reflected a clinical assessment and follow up by a registered nurse.  The managers are aware of their requirement to notify relevant authorities in relation to essential notifications. Appropriate notifications were made relating to a norovirus outbreak in June 2014. |
| 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 in place, including recruitment, selection, orientation and staff training and development. Eleven staff files sampled included evidence of the recruitment process, employment contracts, completed orientation, and annual performance appraisals. The orientation programme provides new staff with relevant information for safe work practice and is developed specifically to worker type. It includes an initial orientation, an intermediate orientation completed within 10 to 16 weeks, an introductory training completed within six months and dementia training within six months of employment. Staff interviewed stated that new staff are adequately orientated to the service. The service has a designated staff educator to support new and existing staff.  A register of practising certificates is maintained.  There is an annual education and training schedule that is being implemented. Education and training for clinical staff is linked to external education provided by the District Health Board.  There are 22 caregivers in the dementia unit. Fifteen of these have completed the required dementia standards and the other seven who have been employed at the service less than 12 months are enrolled and undertaking the required study. Activities staff who work in the dementia unit have completed relevant training. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The staffing levels meet contractual requirements. The general manager, assistant manager and two care managers are registered nurses who are available during weekdays. Adequate RN cover is provided 24 hours a day, seven days a week. RNs are supported by sufficient numbers of caregivers. There are specific caregivers rostered in the service apartments with a draft roster to increase these hours and employ a registered nurse for this area as rest home level resident numbers in the serviced apartments increase. The one current resident is covered by hospital staff when staff are not specifically dedicated in the apartments (for example overnight). Apartment call bells ring to pagers of all duty staff. Interviews with the residents and relatives confirmed staffing overall was satisfactory. |
| 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 into the resident’s individual record. 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 securely. Archived records are secure in separate locked and secure areas.  Residents’ files demonstrate service integration. Entries are legible, timed, dated and signed by the relevant caregiver or nurse including 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 | Residents are assessed prior to entry to the service by the needs assessment team, and an initial assessment with an InterRAI assessment completed on admission. The service has specific information available for residents/families/whānau at entry. The admission agreement reviewed aligned with the ARC contract and exclusions from the service were included in the admission agreement.  Nine signed admission agreements were sighted. The admission agreement reviewed aligns with a) – k) of the ARC contract. Exclusions from the service are included in the admission agreement. The information provided at entry includes examples of how services can be accessed that are not included in the agreement.  There is dementia specific information available to families. The three dementia residents whose files were sampled had NASC approval for the service.  Eight family members interviewed agreed the staff had fully explained services to them on entry to services. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | The registered nurses, enrolled nurse and caregivers interviewed described the documentation and nursing requirements as per the policy for discharge and transfers. Any previous discharge summaries that are relevant are also copied and sent with the transfer documents. These documents are place in a transfer envelope. |
| 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 | Medications are stored appropriately in line with accepted guidelines in all three levels of care. All medications are checked on delivery and discrepancies reported to the pharmacy. The registered nurses, enrolled nurses and senior caregivers administering medications undergo a medication competency.  The medication trolleys are all is kept in locked rooms. All eye drops in use were dated. There are no self-medicating residents. Fridge temperatures are monitored and are within acceptable limits.  The service has implemented a computerised medication management system. Review of the data on the system notes that individual medication charts have photo identification, allergies/adverse reactions noted, and required medications prescribed correctly with indications for use. There is system used to indicate “duplicate name”.  Three monthly reviews by the GP are documented. As required/ sedation / antipsychotic medication administered in the dementia unit all correlate to progress notes indicating a need.  The apartment wing has a medication room and locked medication trolley and will be able to safely provide medications to rest home level care residents. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | There is a food services policy and procedure manual. All food is cooked onsite. A dietitian has reviewed and approved the menu. All residents have a dietary requirements/food and fluid chart completed on admission.  The cook maintains a folder of residents’ dietary requirements that include likes/dislikes. Alternatives are offered and alternatives are provided as needed.  Specialised utensils and lip plates are available as required. Residents and relatives interviewed confirm likes/dislikes are accommodated and alternatives offered. Fridge and freezer temperatures are recorded daily for the kitchen appliances. Perishable foods in the chiller and refrigerators are date labelled and stored correctly. The kitchen is clean and has a good workflow. Chemicals are stored safely and safety data sheets are available. Personal protective equipment is readily available and staff were observed to be wearing hats, aprons and gloves.  The service has implemented ‘subway meals’ this is where resident make and fill their own sandwiches. On the day of audit residents were observed making, filling and eating their own sandwiches, even those with cognitive deficits. The service is commended for this (link 1.1.3).  The kitchen will be able to accommodate meal services for 10 additional rest home level residents in the apartments. |
| 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 reason (no bed availability or unable to meet the acuity/level of care) for declining service entry if this occurs. Potential residents are then referred back to the referring agency. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | The nine resident files sampled included an initial assessment that was undertaken on the day of admission. An InterRAI assessment was completed for all residents admitted since 1 July 2015 as well as a falls, pressure risk, continence, pain and nutrition and fluids assessment within three weeks of admission. These assessments were undertaken at least six monthly or as needs change and served as a basis for care planning. InterRAI six monthly assessments are being introduced at resident’s six monthly file reviews. The activities coordinator completes an activity assessment. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | All nine resident files reviewed identified registered nurses have developed the long-term support plans from information gathered over the first three weeks of admission. All support plans reviewed reflected the outcomes of risk tool assessments. InterRAI CAP’s and triggers were also linked. Interventions clearly described the support required. There was documented evidence of resident/relative/whānau involvement in the support planning process, particularly in the dementia unit.  Files sampled contained short-term care plans to document any changes in health needs with interventions, management and evaluations. Short-term care plans sighted included management of UTI, chest infection, skin infection and wounds (link 1.3.6.1). Short-term care plans reviewed had been evaluated at regular intervals.  Medical GP notes and allied health professional progress notes were evident in the residents integrated files sampled. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Low | All nine care plans sampled documented interventions relevant to current needs.  Two residents with issues documented in the progress notes did not have registered nurse follow up documented.   Dressing supplies are available and the treatment room was well stocked. All staff report that there are adequate dressing supplies and adequate continence products. Specialist wound and continence advice is available as needed through the DHB and the wound and continence product representative.  There were no residents with identified wounds in the dementia unit.  There were five residents with identified wounds in at hospital level, four skin tears and one post-surgical wound. All have an assessment and ongoing wound care plans, although the evaluation of three of those wounds was not comprehensively documented..  There were five resident’s with wounds at rest home level; two were identified as healed pressure injuries that the service continues to monitor. Wound are documented well and evaluated.  There was a short-term care plan in place for all of the wounds.  Behaviour charts, food and fluid charts, fluid balance charts and weekly weighs were sighted to be appropriately completed for residents with related needs. Progress notes are documented at least daily by the caregivers. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | CI | The service employs nine activities staff, two of whom are diversional therapists. The secure dementia unit provides an activities staff member from 09.30 am to 8 pm. Activities are provided at night as needed by night staff.  Activities staff provide activities for rest home, every day including weekends and hospital level care weekdays.  The activity programme includes resident input and has a range of activities to meet most needs at all levels of care including entertainment, craft, walks, memory games music and DVDs. Family are included in the activities. There are also van outings. The activities staff have one-on-one time with residents who are unable or who choose not to participate in the programme.  Dementia specific activities have included (but not limited to) making pizza, fish and chip days, communal sing a-longs and gardening.  The service has exceeded the required standard around the provision of a meaningful activities programme. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | The long-term care plans reviewed evidenced that the plan was amended with each six month review if there were changes identified. Monitoring charts such as weight, blood pressure and pulse, fluid balance charts, food and fluid intake charts, blood sugar level monitoring and behaviour monitoring charts were in use. Short-term care plans reviewed were evaluated regularly with problems resolved or added to the long-term support plan if an ongoing problem. |
| 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 | Referral to other health and disability services is evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. Examples of referrals sighted were to the needs assessment coordination service, physiotherapist and mental health service.  There is evidence of GP discussion with families regarding referrals for treatment and options 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 policies and procedures for the disposal of waste and hazardous material. There is an accident/incident system for investigating, recording and reporting all incidents. Chemical supplies are kept in locked cupboards in the hospital, rest home and dementia units. A contracted supplier provides the chemicals, safety data sheets, wall product charts and chemical safety training as required. Approved containers are used for the safe disposal of sharps. Personal protective equipment is readily available to staff. There is a safe hazardous storage certificate expiring 5th October 2016. |
| 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 holds two current building warrant of fitness’, one for the apartment wing and one for the main wing both expiring 1st May 2016. The service is meeting the relevant requirements as identified by relevant legislation, standards and codes. Hot water temperatures are monitored.  The service employs a maintenance person who carries out minor repairs and maintenance. The maintenance request book is checked and signed off as requests are actioned. Electrical equipment is tested and tagged. Clinical equipment is calibrated annually.  The corridors are carpeted. Bedrooms are either carpet or vinyl. Vinyl surfaces are in all bathrooms/toilets and the kitchen. Corridors are wide and there are handrails in all corridors which promotes safe mobility. Residents were observed moving freely around the areas with mobility aids where required. There are external areas and gardens, which are easily accessible (including wheelchairs). There is outdoor furniture and seating and shaded areas. There are adequate storage areas for the hoist, wheelchairs, products and other equipment. The staff interviewed stated that they have all the equipment referred to in care plans to provide care. There is a designated internal smoking area.  The secure dementia unit has a secure garden area which is freely accessible to residents and includes outdoor furniture and seating and shaded areas.  The maintenance person checks hot water temperatures and undertakes monthly maintenance audits.  This audit reviewed 10 apartments in the apartment wing for rest home level care. All apartments are appropriate for rest home level care residents |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | In the hospital wing all resident room have en-suite toilets and 10 (of 27) have ensuite showers as well. There are also two additional communal shower rooms. There are two communal toilets near the hospital lounge.  In the dementia unit all resident rooms have an ensuite toilet. There are two communal showers.  The rest home has all the rooms have an ensuite with a shower apart from eight rooms. There are two communal showers available.  All apartments have full ensuite facilities.  All showers//toilets have appropriate flooring and handrails. There are privacy locks and shower curtains. |
| 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 | All resident rooms in the facility are single. The resident rooms allow the residents to move about independently with the use of mobility aids. The resident rooms and all apartments have sufficiently wide enough doors for ambulance gurney entry/exit. Residents and their families are encouraged to personalise the bedrooms as sighted. Residents interviewed confirmed their bedrooms are spacious and they can personalise them as they wish. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | All areas (rest home, hospital and dementia unit) have a separate dining area and lounge. Additionally, there are several smaller areas to create a more home-like environment. Seating is placed appropriately to allow for groups and individuals to relax or take part in activities. The wide corridors are light and spacious. Residents were observed safely moving between the communal areas with the use of their mobility aids. There is adequate space to allow for individual and group activities to occur. The apartment area has its own separate lounge which is light and spacious. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | All linen and personal clothing is laundered on site. Adequate linen supplies were sighted. There are cleaners on duty each day for the facility. The cleaner’s chemical cupboards are locked. All chemicals have manufacturer labels. The cleaning trolley is well equipped and stored in a locked area when not in use. Cleaning staff are observed to be wearing appropriate personal protective equipment. The environment on the day of audit was clean and tidy in all areas. The residents interviewed are satisfied with the cleanliness of the communal areas and their bedrooms.  The laundry service will be able to accommodate the additional laundry for ten rest home level residents in the apartments |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | Documented systems are in place for emergency and security situations. There is an evacuation register to guide staff. Regular fire drills are completed. The facility carries civil defence supplies, extra drinking water and food for an emergency plus additional supplies for use in a civil defence and or health emergency (e.g., pandemic). There is access to either gas or electricity for cooking and heating. The facility is staffed by registered nurses 24 hours a day, seven days a week. A large percentage of staff are proficient in first aid and have CPR certificates. There is a call bell system in operation in all areas including the apartment bedrooms and lounges. |
| 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 | All resident rooms and communal rooms have external windows allowing adequate natural light. Windows can be opened safely to allow adequate ventilation. The facility is heated kept at a comfortable temperature. Residents interviewed confirm the environment and the bedrooms are warm and comfortable. The dementia unit is secure. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | Strathallan has an established infection control (IC) programme that is implemented. The infection control programme is appropriate for the size, complexity and degree of risk associated with the service and has been linked into the incident reporting system. The assistant manager is the designated infection control nurse with support from the registered nurses and the quality manager. The IC team meets two monthly to review infection control matters. Regular audits have been conducted and education has been provided for staff. The infection control programme has been reviewed annually. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | There are adequate resources to implement the infection control programme at Strathallan. The infection control (IC) coordinator has maintained her practice by attending infection control updates. The infection control team is representative of the facility. External resources and support are available when required. 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 procedures  Documented 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 | The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes roles, responsibilities, procedures, the infection control team and training and education of staff. The policies are reviewed and updated at least annually. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The facility is committed to the on-going education of staff and residents. Education is facilitated by the staff educator with support from the infection control coordinator. All infection control training has been documented and a record of attendance has been maintained. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak had been resolved. Information is provided to residents and visitors that are appropriate to their needs and this was documented in medical records. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. Individual infection report forms are completed for all infections. Infections are included on a monthly register and a monthly report is completed by the infection control co-ordinator. Infection control data is collated monthly and including in benchmarking. The infection control programme is linked with the quality management programme.  Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GP's that advise and provide feedback /information to the service. Systems in place are appropriate to the size and complexity of the facility. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. The policy includes comprehensive restraint procedures. Interviews with the caregiver and nursing staff confirm their understanding of restraints and enablers. The service has focused on and been successful in reducing the number of residents using restraint.  Enablers are assessed as required for maintaining safety and independence and are used voluntarily by the residents. The service has two residents with bedrails on the enabler register and three hospital residents are on the restraint register. All enabler use is voluntary. |
| Standard 2.2.1: Restraint approval and processes  Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others. | FA | The restraint coordinator is the general manager. The restraint approval process and the conditions of restraint use are recorded on the restraint assessment form. Assessments are undertaken by suitably qualified and skilled staff such as the RN and GP in partnership with the resident and their family/ whanau. The multi-disciplinary team is involved in the assessment process. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | The service completes assessments for residents who require appropriate restraint or enabler intervention. Assessments are undertaken by suitably qualified and skilled staff in partnership with the family/whanau. The restraint assessment form is completed with input from the RN, and GP and the resident’s family and this was documented in the three resident’s files for residents who use restraint. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | The restraint policy requires that restraint is only put in place where it is clinically indicated and justified. The policy requires that restraint, if used, be monitored closely and this is done daily using a monitoring form. The assessment for restraint includes exploring alternatives, other needs and behaviour. Three files were reviewed for residents with restraint. The review identified clear instructions for use of ‘bedrails or the lap belt, approval process, and monitoring requirements.  Restraint monitoring records are completed by staff.  The restraint register is in place and is up to date. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | Three files were reviewed of residents requiring restraint. The use of restraint episodes are evaluated three monthly in the form of a tick box to state whether restraint is required to continue. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | The restraint coordinator is the general manager. The restraint committee at Strathallan includes clinical and non-clinical staff who meet six monthly to review restraint use. An annual audit is completed on restraint use. |

# 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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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.3.6.1  The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Low | The service has a comprehensive wound assessment form and a separate wound management document. The wounds are minor in nature. Not all wound care evaluations document wound progress. Progress notes are documented at least daily and more commonly per shift in all three service levels by the caregivers. RNs interviewed at all three service levels evidenced a high level of resident knowledge and the needs of the individual residents. However follow up of changes in health status was not always documented. | (i)Progress notes reviewed in two of nine files (one rest home and one hospital) did not document RN follow up of identified problems. (ii) In the hospital, wound care evaluations did not adequately describe the progress of the wound. | (i)Ensure that documentation reflects that a registered nurse reviews a resident when there is a change in health status. (ii) Ensure every wound has a comprehensive documented evaluation  90 days |

# Specific results for criterion where a continuous improvement has been recorded

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

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

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

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| Criterion 1.1.3.6  Services are provided in a manner that maximises each consumer's independence and reflects the wishes of the consumer. | CI | Residents interviewed reported that they are supported to be as independent as possible. Examples of promoting independence were sighted in care plans sampled. | In 2014 the service determined that many residents were not choosing to attend the dining rooms for meals and that mealtimes served a function of eating rather than promoting independence and socialising. They determined they would like to improve this.  Initially a ‘breakfast club’ where residents serve themselves (with assistance if necessary) a buffet style breakfast at the time they choose to attend the dining room was initiated in the dementia unit. Following positive results this was rolled out to the ‘rest home’ wing (where hospital and rest home level residents live). The success of this and resident feedback resulted in the commencement of ‘subway lunches’ where residents are provided with a platter of fillings and choose the fillings for their sandwiches and make their own sandwiches (with assistance if necessary).Residents in the hospital with higher cognitive ability and similar interests were provided a quieter lounge with a table to promote attendance and interaction.  An increased number of hospital residents are using the dining room and report that meal times are occasions of friendship. Staff have observed increased interaction between these residents. Residents in the rest home and dementia units have been seen assisting each other to get breakfast and some residents have gained weight. Residents in the rest home who engage in the subway lunches report an increased sense of self-worth and value. The subway meal and dementia breakfast club observed were lively with lots of interaction between residents. Residents and families report that residents have benefited from the independence and friendships gained and this is reflected in resident and family satisfaction survey outcomes. |
| Criterion 1.3.7.1  Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer. | CI | The service has a well-developed activities programme at all three levels of care. Resident and family input into activity planning and families joining in activities is encouraged by the service. The organisation has implemented the Spark of Life programme, with evidence of improved resident outcomes. Residents are specifically invited to attend, and the activities have benefitted individual residents noted by improved communication and general wellbeing and decreased challenging behaviour. Staff have continued the principles outlined in the Spark of life programme throughout the general day and this has shown a consistency of approach. Relatives have commented on the obvious improvements for the resident and their improved relationship as a result. | The service provides a comprehensive activities programme with significant input from residents that exceeds the required standard.  The service recognised that they needed a structured approach to implementing a sustainable and organisation wide approach to continue to create a genuine person centred environment.  The organisation has implemented the Spark of Life programme, with evidence of improved resident outcomes. Residents are specifically invited to attend, and the activities have benefitted individual residents noted by improved communication and general wellbeing and decreased challenging behaviour. Staff have continued the principles outlined in the Spark of life programme throughout the general day and this has shown a consistency of approach. Relatives have commented on the obvious improvements for the resident and their improved relationship as a result. The planned education implementation shows 80% of staff had attended the introductory course, and 40% had completed the Certified Practitioners course.  The increased number of Club programmes and Spark of Life implementation has directly improved resident outcomes.  Although this programme is designed for improved resident outcomes, there is evidence of increased staff satisfaction as they interact with the residents. |
| Criterion 1.4.2.6  Consumers are provided with safe and accessible external areas that meet their needs. | CI | The secure dementia unit has a fully accessible garden for residents to enjoy. | The outdoor area for dementia residents was identified as a ‘wilderness’ with no meaningful spaces. Incident forms noted falls, skin tears and other adverse events occurred outside. This prompted a review. The dementia garden area was well researched and involved a lengthy consultation period with staff, resident and family involvement.  A multi-disciplinary approach included all staff in the unit, families, and a landscaper with research into dementia specific garden areas.  There is now an accessible garden that is aimed specifically at dementia residents; this includes safe plants, walkways, and purposeful walks.  Improved satisfaction by residents and relatives has been seen through satisfaction surveys and feedback from relatives. Incident rates in the dementia garden area have dropped. Falls have reduced as have skin tears, and there has been a reported reduction in agitation. Relatives interviewed on day of audit all praised the garden. |

End of the report.