# Strathallan Healthcare Limited - Strathallan Lifecare

## 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:

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| **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: 17 May 2017 End date: 17 May 2017 |

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

**Total beds occupied across all premises included in the audit on the first day of the audit:** 77

# 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 |
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| | 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 |
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| | 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 Lifecare Village is a Hurst Lifecare Group residential care facility. The service currently provides hospital, rest home and dementia levels of care for up to 88 residents. On the day of audit there were 77 residents living at the facility.

This surveillance audit was conducted against aspects of the 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 a general practitioner.

The service has addressed the previous audit finding around wound care documentation and registered nurse follow up.

The service has maintained previously awarded continuous improvement ratings around: providing a safe environment (dementia) and the Spark of Life activities programme. A further continuous improvement rating has been awarded at this audit around the food services.

## Consumer rights

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| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. | | Standards applicable to this service fully attained. |

A policy on open disclosure is in place. 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. A system for managing complaints is in place.

## Organisational management

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. | | Standards applicable to this service fully attained. |

Services are planned, coordinated and are appropriate to the needs of the residents. A general manager and an assistant manager are responsible for the day-to-day operations of the facility. Quality and risk management processes are maintained, reflecting the principles of continuous quality improvement. Quality goals are documented for the service. Corrective action plans are implemented where opportunities for improvement are identified. A robust health and safety programme is in place, which includes a risk management plan, incident and accident reporting and health and safety processes. Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice, meeting legislative requirements. An 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, 7 days a week. There are adequate numbers of staff on duty to ensure residents are safe.

## Continuum of service delivery

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| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. | | All standards applicable to this service fully attained with some standards exceeded. |

A registered nurse assesses and develops the care plan with the resident and/or family/whānau input. Care plans reviewed demonstrated service integration and were reviewed at least six-monthly by the multidisciplinary team. A diversional therapist oversees the activity team and coordinates the activity programme for the rest home, hospital and dementia level of care residents. The programme includes community visitors and outings, entertainment and activities that meet the individual recreational, physical, cultural and cognitive abilities and preferences for each resident group. Residents and families report satisfaction with the activities programme. Residents are encouraged to maintain links with community groups.

Medication policies reflect legislative requirements and guidelines. Registered nurses are responsible for administration of medicines and complete medication competencies and annual education. The medicine charts reviewed meet prescribing requirements and were reviewed at least three-monthly. The general practitioner reviews medications three-monthly.

Resident food preferences and dietary requirements are identified at admission and all meals are cooked on-site. Food, fluid and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met. There are nutritious snacks available 24 hours.

## 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 service has a current building warrant of fitness.

## Restraint minimisation and safe practice

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| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. | | Standards applicable to this service fully attained. |

The service has restraint minimisation and safe practice policies and procedures in place. Staff receive training in restraint minimisation and challenging behaviour management. On the day of audit there was one resident requiring the use of an enabler and one resident requiring the use of a restraint.

## Infection prevention and control

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| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. | | Standards applicable to this service fully attained. |

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. The service benchmarks infection control data against other villages within the group.

## 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) |
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| **Standards** | 1 | 15 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 3 | 37 | 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) |
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| **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 |
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| Standard 1.1.13: Complaints Management<br><br>The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaints policy describes the management of the complaints process. There are complaint forms available. Information about complaints is provided on admission. A suggestions box is held at reception. Interviews with residents and families demonstrated their understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints.<br><br>A complaints register is being maintained. Seven complaints were lodged in 2016, which include both verbal and written complaints. All complaints held in the register included evidence of an investigation, corrective actions (where indicated) and resolutions.<br><br>Complaints are linked to the quality and risk management system. Discussions with five residents (three rest home and two hospital) and four relatives (two hospital, one dementia and one rest home) confirmed that issues are addressed promptly and that they feel comfortable to bring up any concerns. |
| Standard 1.1.9: Communication<br><br>Service providers communicate effectively with | FA | Residents and relatives have the opportunity to feedback on service delivery through resident meetings (open to family) and annual surveys. Results and areas for improvement are discussed at resident meetings (sighted in minutes) and posted on the resident noticeboard. In the resident survey 2017, respondents reported overall that they were very satisfied with care services. Policies and procedures relating to accident/incidents, complaints and open disclosure, alert staff to their responsibility to notify family/next of kin/EPOA of any accident/incident that |

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| consumers and provide an environment conducive to effective communication. | | occurs. Evidence of communication with family/whānau is documented on accident/incident forms. Sixteen accident/incident forms that were reviewed across the rest home, hospital and dementia unit identified family are kept informed. Relatives interviewed stated that they are kept informed when their family member's health status changes. The Hurst Lifecare's 'vision and values' brochures and posters are visible and available throughout the facility. 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. Interpreter services are available if needed. |
| Standard 1.2.1: Governance<br>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Strathallan Lifecare 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 10 rest home level residents in serviced apartments. On the day of the audit there were 30 hospital level residents and 20 residents in the dementia unit. There are 19 dual purpose beds in the 'rest home' wing; 10 of these beds were occupied on the day of audit by hospital residents. There were 27 rest home level residents including 10 residents in serviced apartments. All residents were under the age related care contract.<br>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.<br>The general manager is an experienced registered nurse with a current practising certificate. She is supported by an assistant manager (RN) 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.<br>The general manager and assistant manager have maintained over eight hours annually of professional development activities related to managing an aged care service. |
| Standard 1.2.3: Quality And Risk Management Systems<br>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement | FA | An established quality and risk management system is being maintained. The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. A system for document control is in place. Any new policies or changes to policy are communicated to staff, evidenced in meeting minutes and in interviews with staff (four caregivers, two RNs, two enrolled nurses (EN), three activities assistants and one cook).<br>Key components of the quality management system include (but are not limited to): monitoring falls; medication errors; restraint use; pressure areas; infections; wounds; and resident satisfaction. Monthly reports submitted to the national quality advisor and the chief executive officer provide a coordinated process between service level and the organisation. There are monthly accident/incident reports that break down the data collected across the rest home, dementia unit, hospital units and staff incidents/accidents. Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. |

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| principles. | | A health and safety programme is in place with strategies implemented to promote staff wellness. The Health & Safety Committee meets bi-monthly. Infections and health and safety matters, such as staff accidents are discussed at the quality meetings and then fed back to the staff meetings. Resident meetings also occur monthly. The internal audit programme monitors key components of the service. If a target is not met or an area of noncompliance is identified, there is evidence of a corrective action plan. |
| Standard 1.2.4: Adverse Event Reporting<br><br>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 incident reports are documented for each incident/accident and are also documented in the residents' progress notes. Documentation includes the action taken and any follow-up action required. Data is linked to the organisation's quality and risk management programme and is used for comparative purposes. Sixteen completed incident forms were reviewed and reflected a clinical assessment and follow up by a RN. Discussions with the general manager confirmed an awareness of the requirement to notify relevant authorities in relation to essential notifications. |
| Standard 1.2.7: Human Resource Management<br><br>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. Ten staff files were reviewed (one assistant manager, four caregivers, three RNs, one enrolled nurse and one activity assistant) and included evidence of the recruitment process, signed employment contracts, police vetting and completed orientation programmes and annual performance appraisals. The orientation programme provides new staff with relevant information for safe work practice. Competencies are completed specific to worker type. Staff interviewed stated that they believed new staff were adequately orientated to the service. A register of current practising certificates for all health professionals is maintained.<br><br>There is an annual education schedule that is being implemented and covers up to two study days annually per employee. Education for RNs is supported by the local DHB. Discussions with staff and management confirmed that a comprehensive education and training programme in relevant aspects of care and support is in place. There are twelve caregivers who work in the dementia unit. Eleven of the caregivers have completed the required dementia standards. The one caregiver who has not yet completed the required dementia standards, has been employed for less than one year and is enrolled in the dementia programme. |

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| Standard 1.2.8: Service Provider Availability<br><br>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 RNs who are available during weekdays. The senior registered nursing staff are rostered to provide after hours on-call support to staff.<br><br>In the hospital, there is a RN on duty on each shift, seven days per week. On the morning shift the RN is supported by an enrolled nurse and six caregivers. On the afternoon shift the RN is supported by a senior caregiver and five caregivers.<br><br>In the rest home, on the morning shift an enrolled nurse is supported by six caregivers. In the afternoons, an RN is on duty 1300-2200 hours and is supported by five caregivers. Additionally, an enrolled nurse is on duty 1600-2300 hours.<br><br>In the dementia unit, an enrolled nurse works 0700-1600 hours. On the morning shift, there are three caregivers on duty. In the afternoons, clinical oversight is provided by the rest home RN. There are four caregivers on duty in the afternoons working various hours.<br><br>On night duty, there is a RN on duty in the hospital. There is one caregiver on duty in the rest home and one in the dementia unit. There are two caregivers rostered on duty in the hospital. Additionally, there is a caregiver (float) on duty who provides cover for staff breaks and assistance in any unit, where needed. The (float) caregiver provides assistance to the rest home residents living in the serviced apartments.<br><br>There are specific caregivers rostered in the service apartments. There are two caregivers rostered on morning and afternoon shifts to provide care to the ten rest home level care residents living in the serviced apartments. The apartment call bells ring to pagers of all duty staff. Interviews with the residents and relatives confirmed staffing overall was satisfactory. |
| Standard 1.3.12: Medicine Management<br><br>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice | FA | There are policies and procedures in place which comply with current legislation. Medicines are stored in accordance with legislation and current guidelines. Medicine administration practice complies with the medicine management policy in the medicine round observed. RNS, ENs and medicine competent care staff administer medications and complete medicine competency and medication management education annually. Medications are prescribed on the electronic medicine management system in accordance with legislative prescribing requirements for all regular, short course and 'as required' medicines. The GPs review the medication charts at least three-monthly. A review of 12 medication signing sheets evidenced that administration of all medications aligned with the medication charts. There were no residents self-administering medications on the day of the audit. |

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| guidelines. | | |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management<br><br>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 on-site. The service employs two qualified cooks. There is a five-week rotating summer and winter menu with dietician input. Special diets such as puree, gluten free, diabetic and vegetarian are accommodated. Snacks are available when the kitchen is closed. All food decanted from original containers is dated. Nutritional assessments and preferences form is completed on admission for each resident. Alternatives are available. Fridges and freezer temperatures are monitored daily. End cook food temperatures are recorded daily. All temperatures are within policy guidelines. Chemicals are stored appropriately. Food safety training occurs annually. Residents interviewed were very complimentary of meals. Breakfast club – buffet style breakfast is available in the dining rooms for residents to choose their breakfast and "subway style" lunches are enjoyed by residents. |
| Standard 1.3.6: Service Delivery/Interventions<br><br>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | The service provides care for residents requiring rest home, hospital and dementia level care. Six files were reviewed for the audit. All six have comprehensive interventions relevant to resident needs.<br><br>Staff have access to adequate medical and continence supplies. Monitoring forms include but are not limited to: vital signs; fluid balance; weight; blood sugar monitoring; falls risk; pressure risk; pain risk; and behaviour monitoring.<br><br>Progress notes reviewed evidenced a follow-up assessment by a RN when a caregiver documented a concern or observation or there was a change in the resident's condition. This previous audit finding has been addressed.<br><br>Wound assessment and management plans are in place for five skin tears (two rest home and three dementia level care residents). All five wound assessments were completed and reviewed within the specified timeframe. All wound assessments reviewed documented progress towards wound healing. This previous audit fining has been addressed. |
| Standard 1.3.7: Planned Activities<br><br>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their | CI | The service employs nine activities staff, two of whom are diversional therapists. The secure dementia unit provides an activities staff member from 9.30 am to 8 pm.<br><br>Activities staff provide activities over seven days per week for dementia, rest home and hospital level care residents.<br><br>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. |

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| needs, age, culture, and the setting of the service. | | Dementia specific activities include (but not limited to): gardening; engaging and interacting with a local mums and toddlers group; cooking; and music.<br><br>The service continues to exceed the required standard around the provision of a meaningful activities programme. |
| Standard 1.3.8: Evaluation<br><br>Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | In all six files reviewed, all initial care plans have been evaluated to develop the long-term care plans in conjunction with the outcomes of the interRAI assessments. In five out of six files, the interRAI assessment and the long-term care plans have been reviewed six-monthly to evaluate progress towards the achievement of the desired goal. In the file of the resident who had been in the facility less than six months, all initial assessments and short-term care plans had been reviewed. Long-term care plans are updated when there is a change in health status. Risk assessments have been reviewed six-monthly and more frequently in the event of a fall or change in health status. Short-term care plans are in place for acute changes in resident needs and are evidenced to be reviewed and signed off by a RN when the issue has resolved or entered into the long-term care plan if not resolved. |
| Standard 1.4.2: Facility Specifications<br><br>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The building has a current warrant of fitness which expires 01 May 2018. |
| Standard 3.5: Surveillance<br><br>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection | FA | The infection control coordinator (RN) uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility.<br>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 coordinator. 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 GPs that advise and provide feedback/information to the service. |

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| control programme. | | |
| Standard 2.1.1: Restraint minimisation<br><br>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. RNs actively seek to minimise the use of any restraints (bed rails or lap belt) and have reduced the use of this equipment. At the time of the audit, the service had one resident using an enabler and one hospital resident requiring the use of a restraint.<br><br>Enablers are assessed as required for maintaining safety and independence and are used voluntarily by the residents. Enablers are still monitored to ensure the resident remains safe. |

# 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 |
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# 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 |
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| Criterion 1.3.13.1<br>Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group. | CI | All food is cooked on-site. The nutritional needs of residents are identified on admission and updated and communicated to the kitchen staff when there is a change to a resident’s nutritional needs. The facility’s food safety plan is implemented. | In 2014, 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 and rest home units. The success of this initiative 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.<br>A hot meal is served in the evenings.<br>The kitchen provides a specific textured diet for residents that require it and staff assist those residents who require help with feeding and fluid intake.<br>Residents in the rest home and dementia units were observed assisting each other to get breakfast. The rest home residents interviewed reported that they enjoy being able to choose what they would like to |

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| | | | eat and the portion size. The residents report feeling able to contribute and assist friends (other residents) at meal times, adding a sense of purpose and value to their day. The subway meal and dementia breakfast club observed lots of positive interaction between residents. Residents and families report that residents feel that they are encouraged to maintain their independence and that the buffet style meals promote a less clinical and more homely approach to meal times. Continuing satisfaction with the food service is reflected in resident satisfaction survey 2017 outcomes.<br><br>A review of weight recordings over the last six months, evidences that most residents in the rest home and dementia units have either gained or remained within their target weight range. One resident in the dementia unit has had some weight loss noted with GP and dietitian input provided into nutritional needs. Snacks are available 24/7 in the dementia unit and the resident with weight loss had been prescribed a nutritional supplement. |
| Criterion 1.3.7.1<br><br>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 for 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 benefited individual residents noted by increasing friendships and general wellbeing and decreased challenging behaviour. | The service continues to implement the Spark of Life philosophy into their activity programme. There are activities programmes across all service areas which are provided over seven days per week.<br><br>Resident involvement in the activity programme is evidenced. Differing groups of five-six residents when out on van outings have been involved in taking photographs for certain categories. The best photographs will be chosen and made into 2018 calendars for residents to give as a gift or family or friends to purchase. Community involvement with the service includes: visits from a mother and toddlers group; links to the local schools and businesses; pet therapy; entertainers; speakers; and gardening and walking clubs.<br><br>Diversional therapists have introduced the 24-hour activity clock to help residents plan their day to include time for activities and times of waking and settling. Staff complete the 24-hour activity clock on consultation with the family/EPOA and from observations of residents in the dementia unit. The introduction of the 24-hour activity clock, activity assistants on duty till 8 pm in the dementia unit and education on the management of challenging behaviours and Spark of Life (meaningful |

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| | | | activities), has seen a reduction in the number of challenging behaviours reported in the dementia unit from 14.5 per 1000 bed nights in January 2016 to 6.1 in March 2017.<br><br>The resident satisfaction survey 2017, evidences overall satisfaction with the activities programme with 97% of respondents reporting that they are very satisfied or satisfied with the programme. |
| Criterion 1.4.2.6<br><br>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 service has continued to improve on the secure garden area in the dementia unit.<br><br>Raised beds have been planted with vegetables and an aviary has been added. There are safe walkways and paths leading to “destination” areas that lead to a continuous walking “loop”, with no dead ends to create possible resident confusion and disorientation.<br><br>Improved satisfaction by residents and relatives has been seen through satisfaction surveys and feedback from relatives. A review of falls data for 2016-2017 evidences a reduction in falls from 45.6 per 1000 bed nights in January 2016 to 25 per 1000 bed nights in March 2017. This reduction in falls has been both attributed to fall prevention strategies implemented and the improved garden layout. Previous analysis evidences that a high number of falls were occurring in the garden area prior to the implementation of the new garden layout.<br><br>Residents were observed walking around the garden, sitting in the shaded seating areas provided and spending time looking and interacting with the pet animals and birds. |

End of the report.