

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](#).

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: 14 November 2018 End date: 15 November 2018

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: 79

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Strathallan Lifecare is part of the Arvida group. The service is certified to provide rest home, hospital and dementia level care for up to 88 residents including rest home level care across 10 serviced apartments. On the day of the audit there were 79 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, management and general practitioner.

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

Two continuous improvement ratings have been awarded around falls reduction and food services.

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.
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Staff at Strathallan Lifecare strive to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner's Code of Consumers' Rights (the Code). The service promotes the attitude of living well (wellness) and introduction of the household model. Residents' cultural needs are met. Policies are implemented to support residents' rights, communication and complaints management. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns have been managed and a complaints register is maintained.

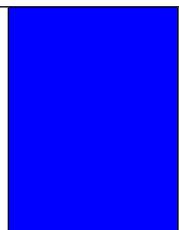
Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Strathallan Lifecare has a current strategic plan and a quality assurance and risk management programme that outlines objectives for the next year. The quality process being implemented includes regularly reviewed policies. Quality projects are implemented. Quality data is reported to the monthly quality assurance meetings. There is an annual internal audit calendar schedule. Residents and relatives are provided the opportunity to feedback on service delivery issues at monthly resident/relative meetings and via annual satisfaction surveys. The introduction of the wellness meeting has given the residents a strong voice into how the facility should be run. There is a reporting process being used to record and manage resident incidents. Incidents are collated monthly and reported to facility meetings. The service has an orientation programme in place that provides new staff with relevant

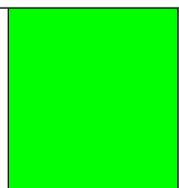
information for safe work practice. The in-service education programme for 2018 is being implemented. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

Continuum of service delivery

<p>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.</p>		<p>All standards applicable to this service fully attained with some standards exceeded.</p>
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An information pack is made available to the resident and family/whānau prior to entry or on admission. InterRAI assessments 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

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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The building has a current building warrant of fitness and maintenance is carried out. Resident rooms are single and personalised. There is adequate room for the safe delivery of care within the residents' rooms. Residents can freely access communal areas using mobility aids. There are communal dining areas, lounges and recreational areas plus smaller seating nooks 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.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Strathallan Lifecare has restraint minimisation and safe practice policies and procedures in place. At the time of the audit there were no residents requiring restraint or enablers. Staff receive training around restraint minimisation and the management of challenging behaviour. A registered nurse is the designated restraint coordinator.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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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 ongoing 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	43	0	0	0	0	0
Criteria	2	91	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](#).

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) policy and procedure is implemented. Discussions with nineteen care staff, (including ten caregivers, four registered nurses (RN), two enrolled nurses (EN), two diversional therapists and one activities coordinator) confirmed their familiarity with the Code. Interviews with ten residents (five rest home and five hospital) and nine families (one rest home in the serviced apartments, four hospital and four dementia care) confirmed the services being provided are in line with the Code. The Code is discussed at resident, staff and quality assurance meetings. Staff receive training on the Code, last occurring in September 2018.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Informed consent processes are discussed with residents and families on admission. Written general and specific consents were evident in the nine resident files reviewed (three hospital, three rest home level, including one resident in the apartments and three dementia level care). Caregivers and registered nurses interviewed confirmed consent is obtained when delivering cares. All advance directives had been appropriately signed by the resident and general practitioner (GP). Advance directives also identified the resident resuscitation status.</p> <p>The service acknowledges the resident is for resuscitation in the absence of a signed directive by the resident. The GP had discussed resuscitation with families/enduring power of attorney (EPOA) where</p>

		the resident was deemed incompetent to make a decision. Discussion with resident's family members identified that the service actively involves them in decisions that affect their relative's lives. Nine admission agreements were sighted for the resident files reviewed. There were two of three dementia files that had activated EPOA on file. The service was working towards accessing the activated EPOA for the other resident.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	A policy describes access to advocacy services. Staff have received training on advocacy. Information about accessing advocacy services information is available in the entrance foyer. This includes advocacy contact details. The information pack provided to residents at the time of entry to the service provides residents and family/whānau with advocacy information. Advocate support is available if requested. Interviews with staff and residents informed they are aware of advocacy and how to access an advocate.
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 are encouraged to be involved in community activities and maintain family and friends' networks. On interview, staff stated that residents are encouraged to build and maintain relationships. All residents and relatives interviewed confirmed that relative/family visiting could occur at any time.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The service has a complaints policy and procedure in place and residents and their family/whānau are provided with information on the complaints process on admission via the information pack. Complaint forms are available at each entrance of the services. Staff are aware of the complaints process and to whom they should direct complaints. A complaints register is available. Four complaints (three in 2018 year to date and one in 2017) have been received at Strathallan Lifecare since the last audit. The complaints reviewed have been managed appropriately with acknowledgement, investigations and responses recorded. Residents and family members advised that they are aware of the complaints procedure and how to access forms.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their	FA	There are posters of the Code on display throughout the facility and leaflets available in the foyer of the facility. The service is able to provide information in different languages and/or in large print if requested. Information is also given to next of kin or enduring power of attorney (EPOA) to read with the resident and discuss. On entry to the service, the village manager or clinical manager discusses

rights.		the information pack with the resident and the family/whānau. The information pack includes a copy of the Code.
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	The service has policies that align with the requirements of the Privacy Act and Health Information Privacy Code. Staff were observed respecting residents' privacy and could describe how they manage maintaining privacy and respect of personal property. There is a policy that describes spiritual care. Church services are conducted regularly. Residents interviewed indicated that residents' spiritual needs are being met when required.
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>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.</p>	FA	The service has established cultural policies to help meet the cultural needs of its residents. There is a Māori health plan in place. There were no residents that identified as Māori at the time of the audit. The service has established links with the local Iwi. Cultural and spiritual practice is supported and identified needs are incorporated into the care planning process. Discussions with the caregivers confirmed that they are aware of the need to respond to cultural differences.
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	The service has established cultural policies aimed at helping meet the cultural needs of its residents. Residents interviewed reported that they were satisfied that their cultural and individual values were being met. Information gathered during assessment including resident's cultural beliefs and values, is used to develop a care plan, which the resident (if appropriate) and/or their family/whānau are asked to consult on. Staff receive training on cultural awareness.
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	The facility has a staff code of conduct which states there will be zero tolerance against any discrimination occurring. The abuse and neglect processes cover harassment and exploitation. All residents interviewed reported that the staff respected them. Job descriptions include responsibilities of the position, ethics, advocacy and legal issues. The orientation and employee agreement provided to staff on induction includes standards of conduct.

<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>CI</p>	<p>The service has policies to guide practice that align with the health and disability services standards, for residents with aged care needs. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training. Residents and families interviewed spoke positively about the care and support provided. Staff interviewed had a sound understanding of principles of aged care and stated that they feel supported by the management team. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training. Arvida is operationalising their vision 'to transform the ageing experience' within the care communities through the introduction of the wellness/household model.</p> <p>The wellness/household model focuses on the relationship between the care team and the resident as partners in the pursuit of a rich and meaningful life. Strathallan Lifecare introduced the wellness/household model in March/April 2018. The emphasis is on supporting each resident to live well and be actively engaged in their life the way they want it to be. Residents are supported within the care communities by decentralised self-led teams of employees that together create home, nurture relationships, determine their own lives and build community. Residents are encouraged and supported to create a comfortable living space suited to their particular needs and personal tastes. The introduction of the wellness meeting has given the residents a strong voice into how the facility should be run.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Residents interviewed stated they were welcomed on entry and given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Fifteen incident/accidents forms reviewed for October 2018 had documented evidence of family notification or noted if family did not wish to be informed. Relatives interviewed confirmed that they are notified of any changes in their family member's health status. Residents interviewed stated that they were welcomed on entry and were given time and explanation about the services and procedures. Interpreter services are available as required.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of</p>	<p>FA</p>	<p>Strathallan Lifecare is owned and operated by the Arvida Group, which was purchased in October 2017. 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 37 hospital level residents, 22 rest home level residents including four residents in serviced apartments and 20 residents in the dementia unit. There are 19 dual-purpose beds in the rest home wing; 11 of these beds were occupied on the day of audit by hospital residents. All residents were</p>

<p>consumers.</p>		<p>under the age-related residential care (ARRC) contract.</p> <p>The village manager reports to the general manager wellness and care on a variety of operational issues and provides a monthly report. Arvida has an overall business/strategic plan. The organisation has a philosophy of care, which includes a mission statement. Strathallan Lifecare has a business plan 2018/2019. Achievements against these plans are recorded on an action plan and are reviewed by the senior operations team at least annually. Regular meetings are held between the village manager and support office as well as weekly meetings between the village manager and clinical manager.</p> <p>The village manager is a RN with a current practising certificate who has been in the role for 12 years and at Strathallan Lifecare for 18 years. She is supported by a clinical manager who has worked at Strathallan Lifecare for 18 years and in the current role for five years. The clinical manager also acts as the assistant manager and is supported by two care managers, one overseeing the hospital wing and the other the rest home wing (containing dual-purpose beds) and the dementia unit.</p> <p>The village manager has maintained over eight hours annually of professional development activities related to managing an aged care service, having recently attended the two-day Arvida manager's forum.</p>
<p>Standard 1.2.2: Service Management</p> <p>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.</p>	<p>FA</p>	<p>In the absence of the village manager, the clinical manager who is also the assistant manager, is in charge. Support is provided by the general manager wellness and care, and the care staff.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>There is a robust and established quality and risk management system in place at Strathallan Lifecare. The quality and risk programme is designed to monitor contractual and standards compliance. There is a 2018/2019 business/strategic plan that includes quality goals and risk management plans for Strathallan Lifecare. The quality and risk management system supports improved resident outcomes and identifies where improvements are required. The village manager is responsible for providing oversight of the quality and risk management system on-site, which is also monitored at organisational level. Interviews with staff and meeting minutes reviewed confirmed that there is discussion about quality data at various facility meetings. Arvida Group policies are reviewed at least every two years across the group. Support office updates or uploads new/revised policies for</p>

		<p>staff to read on the intranet, with email notification of the policies changes.</p> <p>Data is collected in relation to a variety of quality activities and an internal audit schedule has been completed. Areas of non-compliance identified through quality activities are actioned for improvement. All staff interviewed could describe the quality programme corrective action process. Restraint and enabler use (when used) is reported within the quality and clinical staff meetings. Residents/relatives are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families. The overall service result for the resident/relative satisfaction survey completed in March 2018 was at 97%. The survey results have been discussed at the resident/family and staff meetings. Resident/family meetings occur monthly and resident and families interviewed confirmed this.</p> <p>The service has a health and safety management system that is regularly reviewed. Risk management, hazard control and emergency policies and procedures are being implemented and are monitored by the health and safety committee. The health and safety committee has been recently changed to have more representative membership. The village manager has completed specific health and safety training in their role. Hazard identification forms and an up-to-date hazard register are in place, last reviewed in August 2018. Falls prevention strategies are implemented, including identifying residents at higher risk of falling and the identification of interventions on a case-by-case basis to minimise future falls (link 1.1.8.1).</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>There is an accidents and incidents reporting policy. The clinical manager investigates accidents and near misses and analysis of incident trends occurs. There is a discussion of incidents/accidents at staff meetings including actions to minimise recurrence. An RN conducts clinical follow-up of residents. Fifteen incident forms reviewed demonstrated that appropriate clinical follow-up and investigation occurred following incidents. Neurological observation forms were documented and completed for nine reviewed unwitnessed falls with potential head injuries.</p> <p>Discussions with the village manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There has been one section 31 incident notification required since the last audit. The notification was for an unstageable pressure injury in June 2018. A norovirus outbreak in April 2018 was also notified to the public health authorities (link 3.5).</p>
<p>Standard 1.2.7: Human Resource Management</p>	<p>FA</p>	<p>There are human resource management policies in place. This includes that the recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. Twelve staff files were reviewed (one clinical manager, two</p>

<p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>care managers, two RNs, five caregivers, one diversional therapist and one kitchen manager). There is evidence that reference checks were completed before employment was offered. A copy of practising certificates is kept. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Completed orientation is on files and staff described the orientation programme.</p> <p>The in-service education programme for 2017 has been completed and the plan for 2018 is being implemented. Discussions with the caregivers and RNs confirmed that on-line training through Altura is also available. Eight hours of staff development through in-service education has been provided annually. There are 13 RNs and six have completed interRAI training. There are 13 caregivers who work routinely in the dementia unit and ten have completed the dementia standards. Three caregivers are in progress of completing and have commenced work within the last 18 months. The Arvida group hosts two conferences per year for village managers and clinical managers to promote the updating of skills and knowledge.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>Strathallan Lifecare policy includes staff rationale and skill mix. Sufficient staff are rostered on to manage the care requirements of the residents. The service has a total of 144 staff in various roles. Staffing rosters were sighted and there is staff on duty to match needs of different shifts. The village manager and clinical manager work 40 hours per week from Monday to Friday and are available on call after hours. In addition to the village manager, clinical manager and care managers, there is at least one RN on at any one time. The RN on each shift is aware that extra staff can be called on for increased resident requirements. The caregivers interviewed stated that they have sufficient staffing levels.</p> <p>In the hospital unit (27 beds) there are 26 hospital residents. There is a care manager who is supported by one RN on duty in the morning shift and afternoon shifts, and one on the night shift. They are supported by six caregivers (three long and three short shifts) on the morning shift, five (two long and three short shifts) on the afternoon shift and two caregivers on the night shift. In the rest home unit (30 beds, 19 are dual-purpose) there are 18 rest home residents and 11 hospital residents. There is a care manager (rest home/dementia) who is supported by one RN on duty in the morning and afternoon shifts, and one on the night shift. They are supported by six caregivers (three long and three short shifts) on the morning shift, five (two long and three short shifts) on the afternoon shift and one caregiver on the night shift.</p> <p>In the dementia unit (21 beds) there are 20 dementia residents. There is one RN on duty in the morning shift who is supported by an EN and three caregivers on the morning shift and three caregivers on the afternoon shift, and one caregiver on the night shift. The care manager for rest home/dementia shares her time within the two units. The RNs from the hospital cover the rest home</p>

		and dementia units on the afternoon and night shifts. In the serviced apartments (10 beds) there are four rest home residents. There is one EN on duty in the morning shift who is supported by two caregivers on the morning and afternoon shifts. The rest home caregiver covers the night shift in the serviced apartments. Interviews with staff, residents and family members confirmed there are sufficient staff to meet the needs of residents.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The resident files are appropriate to the service type. The service has recently transitioned to an electronic resident management system, eCase. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual electronic record. Residents' files are protected from unauthorised access by being locked away in the nurses' stations and password protected on computers, with security access levels in place. Other residents or members of the public cannot view sensitive resident information. Entries in records are legible, dated and signed by the relevant caregiver or RN.
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' entry into the service is facilitated in a competent, equitable, timely and respectful manner. Residents are assessed prior to entry to the service by the needs assessment (NASC) team, and an initial assessment with an interRAI assessment completed on admission. Admission information packs on the services and levels of care are provided for families and residents prior to admission or on entry to the service. There is specific information provided for families in the dementia unit. The three dementia residents whose files were sampled had NASC approval for the service. All admission agreements reviewed (for long-term residents) aligned with all contractual requirements. Exclusions from the service are included in the admission agreement. A total of nine signed admission agreements were sighted. Nine 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 RNs, 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 placed in a transfer envelope.
Standard 1.3.12: Medicine	FA	Medications are stored appropriately in-line with accepted guidelines in all three levels of care. All

<p>Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>medications are checked on delivery and discrepancies reported to the pharmacy. The RNs, enrolled nurses and senior caregivers administering medications undergo an annual medication competency. The medication trolleys are all 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.</p> <p>Eighteen medication charts were reviewed on the online system. All included individual medication charts with photo identification, allergies/adverse reactions were 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. There is a very low usage of ‘as required’ sedation and antipsychotic medications. The apartment wing has a medication room and locked medication trolley that is managed appropriately.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	CI	<p>There is a food services policy and procedure manual. All food is cooked on-site. A dietitian has reviewed and approved the menu. All residents have a dietary requirements/food and fluid chart completed on admission. The chef 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 confirmed 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. Personal protective equipment is readily available, and staff were observed to be wearing hats, aprons and gloves. There is a verified food control plan.</p> <p>Chemicals are stored safely, and safety datasheets are available. The service has continued with the ‘subway meals’. This is where residents make and fill their own sandwiches, even those with cognitive deficits. This has extended to creating their own pizza toppings. The service has continued to improve the meal services for the residents by introducing a second option at lunch and teatime. Residents commented positively on the second options available. The kitchen staff have embraced the new pure food initiative in conjunction with the clinical staff in a bid to reduce unintentional weight loss through the use of real fresh food instead of using supplements. The satellite kitchen provides meal services for rest home level residents in the apartments. Food is transported by hot boxes. Food temperatures are recorded.</p>
<p>Standard 1.3.2: Declining</p>	FA	<p>The service records the reason (no bed availability or unable to meet the acuity/level of care) for</p>

<p>Referral/Entry To Services</p> <p>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.</p>		<p>declining service entry if this occurs. Potential residents are then referred back to the referring agency.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>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 within expected timeframes. These assessments were undertaken at least six monthly or as needs change and served as a basis for care planning. The activities coordinator completes an activity assessment. Additional assessments include (but are not limited to); management of behaviour, pain, nutrition and wound care were appropriately completed according to need. For the resident files reviewed, the outcomes from assessments and risk assessments were reflected into care plans on eCase.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Resident long-term care plans reviewed on the resident electronic system for were resident focused and individualised. Support needs as assessed were included in the long-term care plans reviewed. The eCase programme identifies interventions that cover a set of goals including managing medical needs/risks. Key symbols on the resident's electronic home page identify current and acute needs such as (but not limited to); current infection, wound or falls risk. Support needs as assessed, were included in the long-term care plans reviewed. Short-term needs are added to the long-term care plan. Care plans evidenced resident (as appropriate) and family/whānau involvement in the care plan process. Relatives interviewed confirmed they were involved in the care planning process. Resident files demonstrated service integration. The three dementia care resident files reviewed had 24-hour activity plans with documented behaviours, triggers and activities to distract and de-escalate behaviours.</p> <p>The long-term care included a detailed behaviour management plan. There was evidence of allied health care professionals involved in the care of the resident including physiotherapist, podiatrist, dietitian and community mental health. One hospital resident had a specific 'End of Life' care plan in place following a change in health status. The contracted physiotherapist has completed transfer plans. Medical GP notes and allied health professional progress notes were evident in the residents integrated electronic files sampled.</p>
<p>Standard 1.3.6: Service</p>	<p>FA</p>	<p>All nine care plans sampled, documented interventions relevant to current needs. When a resident's</p>

<p>Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>condition alters, the RN initiates a review and if required, GP, nurse specialist consultation. Care plans reflect the required health monitoring interventions for individual residents. Computers in each nurse's station allows caregivers the opportunity to sign a task has been completed, (eg, resident turns, fluids given [sited]). Monitoring charts are well utilised. Electronic short-term care plans are utilised for changes to health.</p> <p>Family are notified of all changes to health as evidenced in the electronic progress notes. Registered nurses were regularly involved in resident daily care and ongoing assessments as identified in the progress notes. A weekly evaluation is completed by the RNs. Wound management policies and procedures are in place.</p> <p>Wound assessments, wound management plans and photos were reviewed on eCase. A sample of sixteen wounds records were reviewed including the three current pressure injuries (all grade two). Wound assessment and treatment plans, ongoing evaluation form and evaluation notes were in place for all residents with wounds. The service can access the DHB wound nurse specialist if required. Dressing supplies are available, and the treatment rooms were well stocked. All staff reported 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 or continence product representatives. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified.</p> <p>Residents are weighed monthly or more frequently if weight is of concern. Nutritional requirements and assessments are completed on admission identifying resident nutritional status and preferences. There is dietitian involvement where required (link 1.3.13). Monitoring occurs for weight, blood pressure, blood sugar levels, pain, neurological observations, food and fluid charts. These were sighted across the files reviewed. The RN monitors and reviews the monitoring forms daily on the electronic system. Care staff report any changes to the RN.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>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 8.00 pm. Activities staff provide activities for rest home, every day including weekends, and hospital level care weekdays. Activities for serviced apartment residents include (but not limited to) a circuit walking group, swimming, coffee and chat times.</p> <p>The activity programme includes resident input in line with the wellness/household model 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 are not limited to)</p>

		communal sing-a-longs and dancing, ball games, art and craft and gardening. Individual leisure plans were seen in resident electronic files. The activity coordinators are involved in the six-monthly review with the RN. The service receives feedback and suggestions for the programme through resident wellness meetings, resident integrated meetings and annual survey. The residents interviewed were happy with the activities provided.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	<p>All initial care plans for long-term residents were evaluated by the RN within three weeks of admission. Long-term care plans have been evaluated by the multidisciplinary team at least six-monthly or earlier for any health changes. InterRAI re-assessments have been completed six-monthly in support of reviewing the care plan. All care plans have recently been updated and transferred to the electronic programme. As part of the review and update of the care plans, an evaluation has been completed. Each section of the care plan is evaluated. Family are invited to attend the six-monthly MDT review and informed of any changes if unable to attend.</p> <p>The MDT meeting (now called Case Conference Checklist on the electronic system) includes a holistic evaluation of care and support including input from allied health and medical staff. The GP reviews the residents at least three-monthly or earlier if required. Ongoing nursing evaluations occur as indicated and are documented within the electronic progress notes and short-term changes to care are noted in the relevant care plan section where required. Changes to the electronic long-term care plan identify name and date to reflect the update. Residents and relatives interviewed, confirmed involvement in the Case Conference and evaluation of the care plan.</p>
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. 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	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 datasheets, wall product charts and chemical safety training as

<p>as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>		<p>required. Approved containers are used for the safe disposal of sharps. Personal protective equipment is readily available to staff.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The building holds two current building warrants of fitness, one for the apartment wing and one for the main wing both expiring 1 May 2019. The service is meeting the relevant requirements as identified by relevant legislation, standards and codes. The service employs a maintenance team of three (two full-time and one part-time) who carry 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 maintenance team checks hot water temperatures and undertakes monthly maintenance audits. 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.</p> <p>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 smoking area within the grounds. 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 garden has paths in loops with no dead ends, and areas of interest such as the aviary, raised vegetable gardens and men's areas. The facility continues to improve the outdoor area in the dementia area and are in the process of developing a chicken coop area for the residents.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>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.</p>	<p>FA</p>	<p>The rest home rooms have an ensuite with a shower, apart from eight rooms. There are two communal showers available close to the rooms with no ensuite. In the hospital wing all resident rooms have ensuite toilets and 10 (of 27) have ensuite showers. 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. All apartments have full ensuite facilities. All showers//toilets have appropriate flooring and handrails. There are privacy locks and shower curtains.</p>

<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>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 doors wide enough to accommodate mobility aids and equipment. 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.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>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. There is a small library, and a large community room to accommodate whole facility events. 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.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>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 cleaners' 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 were 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.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>There is an emergency response plan in place to ensure health, civil defence and other emergencies are included. Six monthly fire evacuation practice documentation was sighted, with the last fire evacuation drill occurring on 14 August 2018. All RNs hold a current first aid certificate. There is an approved NZ Fire Service evacuation scheme in place, letter dated 5 February 1999. A contracted service provides checking of all facility equipment including fire equipment. Fire training and security situations are part of orientation of new staff and include competency assessments. Emergency equipment is available at the facility. Short-term backup power for emergency lighting is in place.</p> <p>The facility is well prepared for civil emergencies with two civil defence wheelie bins and a store of emergency water (header tanks and bottled water), and five BBQs for alternative cooking. Emergency food supplies sufficient for three days are kept in the kitchen. There is a store cupboard of supplies necessary to manage a pandemic/outbreak. There are call bells in the residents' rooms, and lounge/dining room areas. Residents were observed to have their call bells in close proximity. There</p>

		are two generators on-site if there is a power failure. The facility is secured at night. The service utilises security cameras.
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	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 and kept at a comfortable temperature. The dementia unit is secure. The residents and family interviewed confirmed temperatures were comfortable during the summer and winter months.
<p>Standard 3.1: Infection control management</p> <p>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.</p>	FA	Strathallan Lifecare 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. The clinical manager is the designated infection control nurse with support from the registered nurses. 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. Visitors are asked not to visit if they are unwell. Hand sanitisers were appropriately placed throughout the facility. Residents are offered the annual influenza vaccine.
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	There are adequate resources to implement the infection control programme at Strathallan Lifecare. The infection control coordinator has attended infection control education within the Arvida group and attends regular meetings with the DHB infection control team and other age care representatives. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The infection control coordinator and infection control committee have good support from the Arvida Group support office, the infection control nurse specialist at the DHB, laboratory technician, GPs and public health. Infection prevention and control is part of staff orientation.
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and</p>	FA	The infection control manual outlines a 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 two-yearly.

<p>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.</p>		
<p>Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The facility is committed to the ongoing education of staff and residents. Education is facilitated by 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.</p>
<p>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.</p>	FA	<p>Infection surveillance is an integral part of the infection control programme and is described in the Arvida group infection control manual. Monthly infection data is collected for all infections based on signs, symptoms and definition of infection. Infections are entered in to the infection register on the electronic database. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and analysed for trends, monthly and annually. Infection control surveillance is discussed at facility meetings. Meeting minutes are displayed for staff. Internal infection control audits are completed with corrective actions for areas of improvement. There has been one norovirus outbreak in April 2018. Documentation demonstrated the outbreak was well managed. The relevant authorities were notified.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service has documented systems in place to ensure the use of restraint is actively minimised and have intentionally minimised restraint use. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. At the time of the audit there were no residents requiring restraint or enablers. The service is committed to maintaining a restraint-free environment. A RN is the designated restraint coordinator. Staff have received training in restraint minimisation in October 2018 and challenging behaviour management in May 2018.</p>

Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>At the end of July 2018, the service identified an improvement was required around the reduction of falls for three residents who were deemed as frequent fallers (nine falls in total for July 2018). The service has been successful in reducing falls for these residents over a three-month period (from 1 August to 30 September 2018).</p>	<p>To achieve falls reduction for three identified frequent fallers, the service implemented a number of initiatives that included (but not limited to); a planned falls prevention programme that reflected the residents falls risk based on a literature review. The programme included strength and balance with individual exercises to reduce falls occurring. Each resident had physiotherapy input. Medical causes were identified and treated. Location and timing of falls analysed for trends. Ongoing education included manual handling and hoist refreshers. Intentional rounding and use of equipment such as sensor mats was also introduced.</p> <p>The result of this programme identified a significant reduction for these three residents (frequent fallers). There was a total of nine falls for July 2018 and since implementing the falls reductions initiatives the total falls over a three-month period (August to September 2018) was nine (four falls in August three in September and two in October). The service continues to review individual strategies for these residents and any other residents that are deemed as frequent fallers.</p>

<p>Criterion 1.3.13.2</p> <p>Consumers who have additional or modified nutritional requirements or special diets have these needs met.</p>	<p>CI</p>	<p>The pure foods initiative was developed in Strathallan Lifecare to maintain and improve resident weights using a natural high protein food supplement rather than prescribed nutritional supplements. The residents selected for the trial all have advanced dementia. The project team included the hospital care manager (project lead) all staff, the dietitian, GP and families of residents concerned.</p> <p>A trial was commenced for 55 days commencing in August 2018. Weigh scales were calibrated prior to the trial. Data was collated and analysed mid-trial and end of the trial. There were dedicated staff to provide continuity and compliance who administered the supplement, and found residents preferred the supplement in a smoothie form, ice cream is added to thicken the consistency.</p>	<p>The pure foods initiative was developed in Strathallan Lifecare to maintain and improve resident weights using a natural high protein food supplement rather than prescribed nutritional supplements. From 1 August to 24 September 2018, three residents gained between 200 to 600gms. Two residents did not complete the trial, one resident gained 1.3kg and another gained 2.8kgs. The residents continue to gain weight through this initiative. Following the completion of the trial, more residents have been included in the initiative and continue to maintain or gain weight.</p> <p>Caregivers have informally commented on the improvement in resident's skin integrity since being on this diet. Relatives interviewed, commented positively on the initiative. Clinical and kitchen staff meet on a monthly-basis to discuss resident weights, menus and improvements or feedback that has been shared from families and staff.</p>
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End of the report.