

# Strathallan Healthcare Limited - Strathallan Lifecare

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## 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 BSI Group New Zealand Ltd, 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:

<b>Legal entity:</b>	Strathallan Healthcare Limited
<b>Premises audited:</b>	Strathallan Lifecare
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 26 January 2021      End date: 26 January 2021
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	75

# Executive summary of the audit

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## 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 75 residents.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Services 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, relatives, management, staff and the general practitioner.

Strathallan Lifecare is managed by a village manager who is appropriately qualified and experienced. She is supported by a clinical manager, two care managers, and a team of experienced staff. The residents and relatives interviewed spoke positively about the care and services provided.

This surveillance audit identified two shortfalls around meeting minutes and medication room temperatures.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Interviews with residents and relatives showed that they are well informed including of changes in residents' health. Management has an open-door policy. Advocacy services are available, and resident (household) meetings take place as planned. 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.		Some standards applicable to this service partially attained and of low risk.
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The quality and risk management programme is implemented. Organisational performance is monitored through several processes to ensure it aligns with the identified values, scope and strategic direction.

There are human resources policies to support recruitment practices. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. An education and training programme for 2020 has been completed. A roster provides sufficient and appropriate coverage for the effective delivery of care and support of residents.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Residents are assessed prior to entry to the service. Initial assessments are completed by a registered nurse, including interRAI assessments. Care plans are based on the interRAI outcomes and other assessments. They are clearly written, and caregivers reported they are easy to follow. Residents interviewed confirmed they were involved in the care planning and review process. Each resident has access to an individual and group activities programme. The group programme is varied. There are policies in place to guide staff in the safe management of medication in line with legislation and guidelines. The general practitioners review residents at least three-monthly. Individual and special dietary needs are catered for. The menu is varied and appropriate. Residents interviewed responded favourably to the meals provided.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The building holds a current warrant of fitness. Resident rooms are single, spacious and personalised. Communal areas within each area are easily accessed with appropriate seating and furniture to accommodate the needs of the residents. External areas

are safe and well maintained. The facility temperature is comfortable and constant. Electrical equipment has been tested and tagged. All medical equipment and hoists have been serviced and calibrated. Hot water temperatures are monitored.

## 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 is restraint free. There are restraint minimisation and safe practice policies and procedures in place. The clinical manager is the designated restraint coordinator. 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.

## 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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Strathallan Lifecare has an infection control programme that complies with current best practice. The infection control programme is designed to link to the quality and risk management system. Records of all infections are kept and provided to head office for benchmarking.

## 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)
<b>Standards</b>	0	14	0	1	1	0	0
<b>Criteria</b>	0	39	0	1	1	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>Strathallan Lifecare 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. The village manager maintains a complaint register. Four complaints were lodged in 2019 and five in 2020, none for 2021 to date. The complaints reviewed have been managed appropriately with acknowledgement, investigations and responses recorded. Complaint forms are available at each entrance of the services. Staff are aware of the complaints process and to whom they should direct complaints. Residents and relatives advised that they are aware of the complaints procedure and how to access forms. Relatives interviewed stated they felt comfortable discussing concerns with the management team, and felt their concerns were addressed appropriately.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment</p>	FA	<p>Residents (two rest home and one hospital) and relatives interviewed (one hospital, and three dementia) 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. Ten incident/accidents forms reviewed for January 2021 had documented evidence of family notification. Relatives interviewed confirmed that they are notified of any changes in their family member's health status. Staff interviewed (one village manager, one clinical manager, two care managers, three registered nurses, one enrolled nurse, seven caregivers, one wellness leader, and one activities coordinator) could easily describe when family would be notified.</p>

conducive to effective communication.		Interpreter services are available as required.
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Strathallan Lifecare is owned and operated by the Arvida Group. 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 a total of 75 residents: 47 hospital level residents, nine rest home level residents including two residents in serviced apartments and 19 dementia level residents.</p> <p>The rest home (dual purpose unit) has 30 beds: 28 residents on the day of the audit including 7 rest home and 21 hospital. The hospital unit has 27 beds: 26 hospital residents on the day. The village manager reported all beds in the rest home and hospital units are dual purpose. All residents were under the age-related residential care (ARRC) contract. There are 21 beds in the dementia unit with 19 residents on the day.</p> <p>The village manager reports to the wellness operations manager on a variety of operational issues and provides a monthly report. Strathallan Lifecare has a business plan 2020-2021. Arvida has an overall business/strategic plan. The organisation has a philosophy of care, which includes a mission statement. 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 regular informal meetings between the village manager, clinical manager and care managers.</p> <p>The village manager is a registered nurse, who has been in her role since February 2020. She has five years' experience at Strathallan as the wellness leader and staff educator. The clinical manager has been in her role since March 2020. She has experience in community nursing and aged care. They are supported by two care managers (across rest home and hospital), 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 attended an Arvida management course, and retirement village course</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</p>	PA Low	<p>Strathallan Lifecare has an established quality and risk management system in place. The quality and risk programme is designed to monitor contractual and standards compliance. There is a 2020-21 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.</p> <p>The internal audit schedule is linked to the quality plan, and a range of monthly data is collated including infection rates. Corrective actions are documented, signed off when completed and results are discussed at the combined</p>

<p>system that reflects continuous quality improvement principles.</p>		<p>quality meeting, however these were not evidenced as being discussed at the staff meeting.</p> <p>An annual resident/relatives survey was last held for 2019. The 2020 results had not yet been collated at the time of the audit. The survey evidenced overall satisfaction with the service. Ninety percent of respondents thought staff were respectful, 84% were satisfied with the accommodation, 61% were happy with the variety and choice of meals, dining experience and the quality and taste of meals. Fifty-eight percent of residents were happy with the activities. The survey results have been discussed at the resident/family and staff meetings. Corrective actions were completed around areas of lower satisfaction.</p> <p>The service is currently undergoing changes to the service to accommodate the wellness/household model of care. Resident/family (household) meetings occur monthly, and resident and relatives interviewed confirmed this. There are three household meetings for the facility (hospital, dementia and the rest home). There is a separate culinary committee which started in October 2020. There is a resident committee from across the service. The committee meet with the catering manager to discuss the menu, residents likes/dislikes, and aligns with the 'eating well' pillar of care.</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 combined quality/health and safety/infection control committee. The combined quality/health and safety/infection control committee is representative of the facility. A monthly health and safety report is included in the monthly reporting to head office. Hazard identification forms are paper-based and are entered onto the electronic system by the registered nurse or care manager. An up-to-date hazard register is in place, last reviewed in September 2020. Health and safety education is provided through the electronic system, and during induction to the service which is monitored by the educator (not available on the day of the audit). There are monthly Zoom online meetings held with the health and safety team from support office. Staff interviewed from all disciplines were knowledgeable around health and safety practices for their workplace.</p> <p>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.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the</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 quality, clinical and head of department meetings (link 1.2.3.6) including actions to minimise recurrence. Ten incident reports were reviewed (three dementia, four rest home and three hospital). All incidents evidenced next of kin (NOK) notification, and registered nurse follow up. Neurological observations were completed for all unwitnessed falls or suspected head injuries. Opportunities to minimise future risks were implemented (where possible) including physiotherapy input.</p> <p>Discussions with the management team confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been three section 31 notifications completed since the</p>

<p>service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>last audit – two stage 3 pressure injuries and one resident wandering.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>There are human resource management policies in place. The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. Eight staff files were reviewed (one clinical manager, one care manager/RN, three caregivers, one enrolled nurse, one maintenance and one kitchenhand). There is evidence that reference checks were completed before employment was offered. Annual staff appraisals were evident in all staff files reviewed. 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>An in-service education and competency programme plan for 2020 has been completed with electronic spreadsheets maintained of staff attendance. The village manager, clinical team leaders and RNs are able to attend external training, including sessions provided by the local district health board (DHB). Discussions with the caregivers and the RNs confirmed that ongoing online aged care training is encouraged and supported by the service. Eight hours of staff development or in-service education has been provided annually. Eight of 14 registered nurses (including the care managers) and one of five enrolled nurses have completed interRAI training.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>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, clinical manager and care managers 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 residents, relatives and caregivers interviewed stated that they have sufficient staffing levels.</p> <p>Hospital / rest home care manager (RN) works Monday to Friday 9am to 5.30pm.</p> <p>Dementia care manager (RN) works Monday to Friday 7.30am to 4pm</p> <p>The 10 serviced apartments (currently two residents receiving rest home level care) have a registered nurse from 8.30 am to 5 pm Monday to Friday. She is supported by two caregivers in the mornings: 1x 7 am to 3 pm, and 1x 7 am to 12.45 pm.</p>

	<p>The afternoon shift is covered by two caregivers: 1x 3 pm to 11 pm, and 1x 2.30 pm to 10 pm. The caregivers from the rest home unit assist residents during the night.</p> <p>The hospital unit has 27 beds with 26 residents (all hospital level care).</p> <p>The morning shift has a registered nurse from 6.45 am to 3.15 pm, and an enrolled nurse from 7.30 am to 3 pm on the morning shifts.</p> <p>They are supported by six caregivers; 2x 7 am to 3 pm, 1x 7 am to 1.30 pm, 2x 7.30 am to 1 pm, and 1x 7.30 am to 12.30 pm.</p> <p>The afternoon shift has one registered nurse from 2.45 pm to 11.15 pm, who is supported by six caregivers rostered: 1x 3 pm to 11 pm, 1x 3 pm to 10 pm, 1x 4 pm to 9 pm, 1x 4 pm to 9.30 pm, 1x 4.30 pm to 10 pm, and 1x 5 pm to 10 pm.</p> <p>The night shift has one registered nurse from 10.45 pm to 7.15 pm who is supported by two caregivers from 11 pm to 7 am.</p> <p>The rest home unit has 30 beds with 28 residents including seven rest home and 21 hospital level.</p> <p>The morning shift has a registered nurse from 7 am to 3.30 pm, the enrolled nurse works from 7.30 am to 4.15 pm.</p> <p>They are supported by six caregivers; 1x 7 am to 3.30 pm, 1x 7 am to 3 pm, 1x 7.30 am to 12.30 pm, 1x 7.30 am to 1.15 pm, 1x 7 am to 9.30 am, 1x 9.30 am to 1 pm.</p> <p>The afternoon shift has one registered nurse from 2.30 pm to 11 pm, and one enrolled nurse from 4 pm to 11 pm.</p> <p>They are supported by five caregivers: 1x 2.30 pm to 11 pm, 1x 4 pm to 10 pm, 1x 4.45 pm to 9.15 pm, 1x 5 pm to 10 pm, and 1x 6 pm to 9.30 pm.</p> <p>The dementia unit has 21 beds – 19 residents.</p> <p>The enrolled nurse is rostered from 7.30 am to 4 pm.</p> <p>She is supported by three caregivers; 1x 6.30 am to 2.30 pm, 1x 6 am to 12 md, 1x 7 am to 3 pm.</p> <p>The afternoon shift has three caregivers 1x 4.30 pm to 10 pm (medication competent), 1x 4 pm to 11 pm and 1x 4 pm to midnight.</p> <p>The night shift has one caregiver from 11 pm to 7 am.</p> <p>There are two activities coordinators in the dementia unit across seven days; 1x 9.30 am to 5 pm, 1x 4 pm to 8 pm</p>
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		and another activities coordinator works from 3.15 pm to 5.15 pm over the weekends.
<p><b>Standard 1.3.12: Medicine Management</b></p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Moderate</p>	<p>Twelve medication charts were reviewed. Medication management is implemented using an electronic system and blister packs from a contracted pharmacy. Medications are delivered to the facility monthly and checked against the electronic prescription and signed by an RN. Input is available from the pharmacist on request. Pharmacist input was evident in the recent medication review of a resident receiving specialised dementia care.</p> <p>Non-packaged medications were stored in a locked cupboard and showed evidence of stock rotation. All medications sighted were within the recommended use by dates. Medication fridge temperatures and medication room temperatures were recorded daily, however, the medication room temperatures were not always recorded to be within the expected range. Storage systems for medicines are locked within rooms with restricted entry.</p> <p>Good prescribing practices were noted on the electronic medication management system. The reasons for pro re nata (PRN) medications met the required standard. The requirement for three monthly review by a GP was met and due dates consistently recorded on the medication chart.</p> <p>At the time of audit there were no residents who were self-administering their medications. There are no standing orders. The RNs, enrolled nurses and senior caregivers administering medications undergo an annual medication competency.</p>
<p><b>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</b></p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<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. The chef/catering manager and kitchenhand interviewed explained the process of communication between the care staff and the kitchen. Specialised utensils and lip plates are available as required. This was observed to be used for residents in the dementia unit. Residents and relatives interviewed confirmed likes/dislikes are accommodated and alternatives offered. Fridge and freezer temperatures are recorded daily for the kitchen appliances and calibration occurs 12- weekly. 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>The service has continued with to provide for two options on the menu where the residents can choose what they want for the day. Residents are provided with opportunities to create their own pizza and sandwich fillings. There is a buffet style breakfast until 9.30 am and is available across the service with snacks available over 24 hours. Pure foods are the basis for fortified purees and soups, and this is also used for residents with unintentional weight loss. The satellite kitchen provides meal services for rest home level residents in the apartments. Food is transported by</p>

		hot boxes. Food temperatures are recorded. Chemicals are stored safely, and safety datasheets are available.
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>All six care plans sampled: documented interventions relevant to residents' current needs. When a resident's condition alters, the RN initiates a review and requests input from the GP as required. The interview with the GP confirmed that discussion and referral to allied health professionals took place in a timely manner. Care plans reflect the required health monitoring interventions for individual residents. Monitoring charts are well utilised. Care plans are electronic and are updated when there are changes to health, requiring updated interventions.</p> <p>Family was 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. Registered nurses evaluate care provided by enrolled nurses and caregivers by regular entry in progress notes.</p> <p>Wound assessments, wound management plans and photos were reviewed on eCase. A sample of seventeen wounds records were reviewed across the service including five current pressure injuries (one stage three, two stage two and two stage one), chronic leg ulcers, complex skin tears and skin lesions. Wound assessment and treatment plans, ongoing evaluation form and evaluation notes were in place for all residents with wounds. Minor skin tears have a short-term care plan. The service can access the DHB wound nurse specialist if required and this was evident with the management of the stage two and stage three pressure injuries and also chronic leg ulcers. Specialised equipment including hoists, transfer belts, pressure relieving mattresses and cushions were available for use. Dressing supplies are available, and the treatment rooms were well stocked. All staff reported that there are adequate dressing supplies and adequate continence products.</p> <p>A continence product representative/trainer is involved in supporting the facility in management of continence product needs. A range of continence products are available and resident files include a urinary continence assessment, bowel management, and type of 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. 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</p>	FA	<p>The service employs seven activities staff including one diversional therapist (wellness leader). The secure dementia unit provides an activities staff member from 9.30 am to 8 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, Arvida five pillars of</p>

<p>consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>wellness 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) 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.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Care plans reviewed were updated as changes were noted in care requirements. Care plan evaluations were reviewed in five of six care plans that had been for six months or longer and reflect progress against the documented goals.</p> <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 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. Electronic care plans are updated following interRAI assessment. An evaluation has been completed of each care plan section as part of the care plan review.</p> <p>The case conference checklist on the electronic system includes a holistic evaluation of care and support including input from allied health and medical staff. Family are invited to attend the six-monthly case conference meetings to discuss the plan of care. Residents and relatives interviewed confirmed involvement in the Case Conference and evaluation of the care plan.</p> <p>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.</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 2021. The service is meeting the relevant requirements as identified by relevant legislation, standards and codes. The service employs a maintenance team of four (two full-time and two part-time) who carry out minor repairs, maintenance and gardening. The maintenance person/gardener interviewed described checking the maintenance/request book and signing 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. The secure dementia unit has a secure garden area which is freely accessible to residents and includes an indoor-outdoor flow.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>The infection control surveillance programme is implemented. Electronic infection events are collected and analysed monthly. The infection events, trends and analysis are reviewed by the infection control coordinator (care manager/ RN) and the clinical manager and data is forwarded to head office for benchmarking. This information is then communicated to all staff through clinical and quality meetings; however, this was not evident at the staff meetings (link 1.2.3.6). Infection control audits are completed, and corrective actions are signed off.</p> <p>There was additional infection control training held around Covid-19 including donning and doffing personal protective equipment and monitoring of staff processes. There were no corrective actions following the district health board Covid-19 audit. The pandemic plan has been updated to include Covid-19, and guidelines of alert level requirements are available. Adequate supplies of personal protective equipment were sighted.</p> <p>The management team reported there have been no outbreaks since the previous audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Strathallan Lifecare 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. The clinical manager is the designated restraint coordinator. Staff have received training in restraint minimisation during 2020 via the online education system.</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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	PA Low	There are a range of meetings held including combined quality, health and safety and infection control, head of department meetings, clinical management team meetings, and monthly staff meetings. Quality data and corrective actions are discussed at the combined quality meeting; however, the minutes of the staff meetings did not reflect discussion around quality data.	There was no documented evidence of discussion around quality data and corrective actions at the staff meetings.	<p>Ensure the meeting minutes reflect discussions around quality data at staff meetings.</p> <p>90 days</p>
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration,</p>	PA Moderate	The medication policy is current and reflects the medication care guides for residential care. Registered nurses and clinical coordinator could explain the reconciliation and disposal of medication. Unused, expired and damaged medicines, including PRN medicines are returned to the pharmacy for safe disposal. Medication fridge temperatures are consistently recorded between 2-8 degrees Celsius. Medication storage	Two of the three storage areas have temperatures recorded above 25 degrees Celsius with no recorded corrective actions taken to lower	Maintain the recommended temperatures for the areas where medicines are being stored and ensure corrective

<p>review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>		<p>areas are locked when unattended and the temperatures are monitored daily, however the temperatures for all storage areas were not consistent below 25 degrees Celsius.</p>	<p>the room temperature. One temperature was recorded as 32 degrees Celsius in October 2020.</p>	<p>action is taken if temperatures are outside the required range.</p> <p>30 days</p>
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## Specific results for criterion where a continuous improvement has been recorded

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

No data to display
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End of the report.