**Dixon House Trust Board**

**Current Status:** **28-Aug-13**

**The following summary has been accepted by the Ministry of Health as being an accurate reflection of the** **Surveillance audit conducted against the Health and Disability Services Standards – NZS8134.1:2008; NZS8134.2:2008 & NZS8134.3:2008 on the audit date(s) specified.**

**General overview**

Dixon House is certified to provide rest home level care for up to 37 residents. There are documented mission, values and goals for Dixon House. The service has a documented quality and risk management system. The rest home manager is a registered nurse who has been in the role for 18 months. She is supported by two registered nurses, enrolled nurses and care staff. Residents and families interviewed were supportive of the care and support provided.

The shortfall identified at the previous certification audit relating to medication management, continues to require improvement.

This audit identified improvements required relating to maintaining a complaints register, developing a current quality plan, reviewing content of policies and procedures, conducting a resident survey, developing corrective actions when required for identified shortfalls, ensuring RN follow up following incidents and accidents, reporting all adverse events, ensuring the RN reviews and signs off all care plans, ensuring that assessments are conducted for all resident care issues, aspects of medication management, ensuring the menu is reviewed by a dietitian, and conducting six monthly fire drills.

Verification of three additional beds was conducted for the increased capacity. All five upstairs studio units are large enough to accommodate couples and the small lounge now used as a resident’s room is spacious and private. Three other lounge areas remain accessible to residents at Dixon House.

This brings the capacity to 40 residents at Dixon House.

**Audit Summary AS AT** **28-Aug-13**

Standards have been assessed and summarised below:

**Key**

| **Indicator** | **Description** | **Definition** |
| --- | --- | --- |
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

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| **Consumer Rights** | Day of Audit  28-Aug-13 | Assessment |
| 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. |  | **Some standards applicable to this service partially attained and of low risk** |

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| **Organisational Management** | Day of Audit  28-Aug-13 | Assessment |
| 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 medium or high risk and/or unattained and of low risk** |

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| **Continuum of Service Delivery** | Day of Audit  28-Aug-13 | Assessment |
| 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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| **Safe and Appropriate Environment** | Day of Audit  28-Aug-13 | Assessment |
| 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. |  | **Some standards applicable to this service partially attained and of low risk** |

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| **Restraint Minimisation and Safe Practice** | Day of Audit  28-Aug-13 | Assessment |
| 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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| **Infection Prevention and Control** | Day of Audit  28-Aug-13 | Assessment |
| 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** |

Dixon House Rest Home

Dixon House Trust Board

Surveillance audit & Verification audit

Audit Report

Audit Date: 28-Aug-13

Audit Report

To: HealthCERT, Ministry of Health

|  |  |
| --- | --- |
| **Provider Name** | Dixon House Trust Board |

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| --- | --- | --- | --- |
| **Premise Name** | **Street Address** | **Suburb** | **City** |
| Dixon House Rest Home | 6 Brunner Street |  | Greymouth |

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| --- |
| **Proposed changes of current services** (*e.g. reconfiguration*)**:** |
| The service is using two studio apartments currently certified for single residents for double rooms and one room that was previously a lounge for rest home level care. |

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| --- | --- |
| **Type of Audit** | Surveillance audit and (*if applicable*) Verification audit |
| **Date(s) of Audit** | **Start Date:** 28-Aug-13 **End Date:** 28-Aug-13 |
| **Designated Auditing Agency** | Health and Disability Auditing New Zealand Limited |

# Audit Team

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Audit Team** | **Name** | **Qualification** | **Auditor Hours on site** | **Auditor Hours off site** | **Auditor Dates on site** |
| Lead Auditor | XXXXXXX | RCpN, Health Auditor,AdDipBusMan, Cert QA | 8.00 | 4.00 | 28-Aug-13 |
| Auditor 1 |  |  |  |  |  |
| Auditor 2 |  |  |  |  |  |
| Auditor 3 |  |  |  |  |  |
| Auditor 4 |  |  |  |  |  |
| Auditor 5 |  |  |  |  |  |
| Auditor 6 |  |  |  |  |  |
| Clinical Expert |  |  |  |  |  |
| Technical Expert |  |  |  |  |  |
| Consumer Auditor |  |  |  |  |  |
| Peer Review Auditor | XXXXXXX | RCompN, PGDipHSM, Health auditor |  | 1.00 |  |

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| --- | --- | --- | --- | --- | --- |
| **Total Audit Hours on site** | 8.00 | **Total Audit Hours off site** *(system generated)* | 5.00 | **Total Audit Hours** | 13.00 |
| **Staff Records Reviewed** | 4 of 40 | **Client Records Reviewed** *(numeric)* | 4 of 40 | **Number of Client Records Reviewed using Tracer Methodology** | 1of 4 |
| **Staff Interviewed** | 10 of 40 | **Management Interviewed** *(numeric)* | 2 of 2 | **Relatives Interviewed** *(numeric)* | 2 |
| **Consumers Interviewed** | 8 of 40 | **Number of Medication Records Reviewed** | 8 of 40 | **GP’s Interviewed (aged residential care and residential disability)** *(numeric)* | 1 |

# Declaration

I, (full name of agent or employee of the company) XXXXXXX (occupation) Director of (place) Christchurch hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf ofHealth and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Act.

I confirm that Health and Disability Auditing New Zealand Limitedhas in place effective arrangements to avoid or manage any conflicts of interest that may arise.

Dated this 17 day of September 2013

Please check the box below to indicate that you are a DAA delegated authority, and agree to the terms in the Declaration section of this document.

This also indicates that you have finished editing the document and have updated the Summary of Attainment and CAR sections using the instructions at the bottom of this page.

Click here to indicate that you have provided all the information that is relevant to the audit: 🗷

The audit summary has been developed in consultation with the provider: 🗷

Electronic Sign Off from a DAA delegated authority (*click here*): 🗷

# Services and Capacity

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  | **Kinds of services certified** | | | | | | | | | | | | |
|  |  |  | Hospital Care | | | | | | | Rest Home Care | | Residential Disability Care | | | |
| **Premise Name** | **Total Number of Beds** | **Number of Beds Occupied on Day of Audit** | **Number of Swing Beds for Aged Residen-tial Care** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dixon House Rest Home | 40 | 40 |  | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 |
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Executive Summary of Audit

General Overview

Dixon House is certified to provide rest home level care for up to 40 residents with 37 residents accommodated on the day of the surveillance audit. There are documented mission, values and goals for Dixon House. The manager is a registered nurse who has been in the role for 18 months. She is supported by two registered nurses, enrolled nurses and care staff. Residents and families interviewed were supportive of the care and support provided.

The shortfall identified at the previous certification audit relating to medication management, continues to require improvement.

This audit identified improvements required relating to maintaining a complaints register, a quality plan, reviewing content of policies and procedures, resident survey, internal audits, corrective action planning, RN follow up following incidents and accidents, reporting all adverse events, staff training, registered nurse reviews and signs off care plans, assessments, aspects of medication management, ensuring the menu is reviewed by a dietitian, and conducting six monthly fire drills.

1.1 Consumer Rights

The service has an open disclosure policy stating residents and/or their representatives have a right to full and frank information and open disclosure from service providers. There is a complaints policy and an incident/accident reporting policy. Family members are informed in a timely manner when their family members health status changes. Education on informed consent has been provided. The complaints process and forms for completion were viewed on various notice boards throughout the facility. Brochures are also freely available for the Health and Disability and advocacy service with contact details provided. Information on how to make a complaint and the complaints process are included in the admission booklet and displayed throughout the facility. An improvement is required whereby a complaints register is maintained.

1.2 Organisational Management

Dixon House operates as a combined churches trust with the manager reporting to a board. The organisation has a quality and risk management plan is in place. An improvement is required whereby a current annual quality plan is developed to include the quality activities undertaken. A quality management meeting is held to report and discuss quality and resident issues. Internal audits are conducted, however, clinical audits need further development and there has been no resident survey. This is an area requiring improvement. Incident and accident, and infection rates are reported with an analysis completed monthly for the quality meeting. Improvements are required around quality activities to ensure identified issues are followed through. Incident and accidents also require completion and follow up from the registered nurse and the manager. All adverse events including pressure injuries are required to be reported via the incident and accident reporting process. These are areas requiring improvement. There are human resource policies and procedures in place. In-service training is provided in addition to the aged care education programme (ACE). Rosters are in place. Registered nurses provide on call service. The roster provides sufficient and appropriate coverage for effective delivery of care and support for the facility.

1.3 Continuum of Service Delivery

The registered and enrolled nurses are responsible for each stage of service provision. A care plan is developed using information from assessments in consultation with the resident and family/whanau where appropriate with exceptions. Improvements are required whereby all assessments are conducted for identified issues and each care plan is reviewed and signed off by a registered nurse. Care plans are individualised, up-to-date and reflect current service delivery requirements for each resident. The plans are reviewed at least six monthly. Short term care plans are utilised for changes in health status such as infections and wounds. General practitioners conduct clinical reviews at least three monthly . Residents and relatives interviewed are complimentary about the care provided. Activities are provided that reflect ordinary patterns of life and encourage residents to remain integrated in their community. There are medication management policies and procedures in place which require review to align with current guidelines. Medications are administered by registered nurses, enrolled nurses and/or some care staff. Only care staff have completed annual medication competencies. Improvements are required whereby registered and enrolled nurses complete annual medication competencies. Further aspects of medication management require improvement relating to controlled drug administration, transcribing of medication orders, prescribing of 'as required' medications, documentation of allergies and medication review timeframes. Special diets are catered for to meet residents' needs and specialist input is accessed as required. The current menu requires review from a registered dietitian.

1.4 Safe and Appropriate Environment

Dixon House provides a safe, secure and appropriate environment for the care of older persons with rest home needs. The service has a current building warrant of fitness dated 1 July 2014. An improvement is required whereby fire drills are conducted six monthly.

2 Restraint Minimisation and Safe Practice

There is a restraint policy that includes definitions of restraint and enablers. There are no residents assessed as requiring restraint or enablers. Staff are trained in restraint minimisation and managing challenging behaviours.

3. Infection Prevention and Control

The infection control nurse completes a monthly infection summary which is discussed at quality and staff meetings. Infection control education is provided and records maintained. All infections are recorded on the surveillance monitoring summary.

Summary of Attainment

* 1. Consumer Rights

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.1.1 | Consumer rights during service delivery | Not Applicable | 0 | 0 | 0 | 0 | 0 | 1 |
| Standard 1.1.2 | Consumer rights during service delivery | Not Applicable | 0 | 0 | 0 | 0 | 0 | 4 |
| Standard 1.1.3 | Independence, personal privacy, dignity and respect | Not Applicable | 0 | 0 | 0 | 0 | 0 | 7 |
| Standard 1.1.4 | Recognition of Māori values and beliefs | Not Applicable | 0 | 0 | 0 | 0 | 0 | 7 |
| Standard 1.1.5 | Recognition of Pacific values and beliefs |  | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.1.6 | Recognition and respect of the individual’s culture, values, and beliefs | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.1.7 | Discrimination | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.1.8 | Good practice | Not Applicable | 0 | 0 | 0 | 0 | 0 | 1 |
| Standard 1.1.9 | Communication | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.1.10 | Informed consent | Not Applicable | 0 | 0 | 0 | 0 | 0 | 9 |
| Standard 1.1.11 | Advocacy and support | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.1.12 | Links with family/whānau and other community resources | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.1.13 | Complaints management | PA Low | 0 | 1 | 1 | 0 | 0 | 3 |

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| Consumer Rights Standards (of 12): N/A:10 CI:0 FA: 1 PA Neg: 0 PA Low: 1 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 48): CI:0 FA:3 PA:1 UA:0 NA: 0 |

* 1. Organisational Management

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|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.2.1 | Governance | FA | 0 | 2 | 0 | 0 | 0 | 3 |
| Standard 1.2.2 | Service Management | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.2.3 | Quality and Risk Management Systems | PA Moderate | 0 | 4 | 4 | 0 | 0 | 9 |
| Standard 1.2.4 | Adverse event reporting | PA Moderate | 0 | 1 | 1 | 0 | 0 | 4 |
| Standard 1.2.5 | Consumer participation |  | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.2.6 | Family/whānau participation |  | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.2.7 | Human resource management | PA Low | 0 | 3 | 1 | 0 | 0 | 5 |
| Standard 1.2.8 | Service provider availability | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 1.2.9 | Consumer information management systems | Not Applicable | 0 | 0 | 0 | 0 | 0 | 10 |

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| Organisational Management Standards (of 7): N/A:2 CI:0 FA: 2 PA Neg: 0 PA Low: 1 PA Mod: 2 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 34): CI:0 FA:11 PA:6 UA:0 NA: 0 |

* 1. Continuum of Service Delivery

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.3.1 | Entry to services | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.3.2 | Declining referral/entry to services | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.3.3 | Service provision requirements | PA Low | 0 | 2 | 1 | 0 | 0 | 6 |
| Standard 1.3.4 | Assessment | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.3.5 | Planning | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.3.6 | Service delivery / interventions | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.3.7 | Planned activities | FA | 0 | 1 | 0 | 0 | 0 | 3 |
| Standard 1.3.8 | Evaluation | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.3.9 | Referral to other health and disability services (internal and external) | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.3.10 | Transition, exit, discharge, or transfer | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.3.11 | Use of electroconvulsive therapy (ECT) |  | 0 | 0 | 0 | 0 | 0 | 4 |
| Standard 1.3.12 | Medicine management | PA Moderate | 0 | 2 | 2 | 0 | 0 | 7 |
| Standard 1.3.13 | Nutrition, safe food, and fluid management | PA Low | 0 | 2 | 1 | 0 | 0 | 5 |

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| Continuum of Service Delivery Standards (of 12): N/A:6 CI:0 FA: 3 PA Neg: 0 PA Low: 2 PA Mod: 1 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 51): CI:0 FA:10 PA:4 UA:0 NA: 0 |

* 1. Safe and Appropriate Environment

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|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.4.1 | Management of waste and hazardous substances | Not Applicable | 0 | 0 | 0 | 0 | 0 | 6 |
| Standard 1.4.2 | Facility specifications | PA Low | 0 | 2 | 1 | 0 | 0 | 7 |
| Standard 1.4.3 | Toilet, shower, and bathing facilities | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.4.4 | Personal space/bed areas | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.4.5 | Communal areas for entertainment, recreation, and dining | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.4.6 | Cleaning and laundry services | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.4.7 | Essential, emergency, and security systems | Not Applicable | 0 | 0 | 0 | 0 | 0 | 7 |
| Standard 1.4.8 | Natural light, ventilation, and heating | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |

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| Safe and Appropriate Environment Standards (of 8): N/A:7 CI:0 FA: 0 PA Neg: 0 PA Low: 1 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 36): CI:0 FA:2 PA:1 UA:0 NA: 0 |

1. Restraint Minimisation and Safe Practice

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|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 2.1.1 | Restraint minimisation | FA | 0 | 1 | 0 | 0 | 0 | 6 |
| Standard 2.2.1 | Restraint approval and processes | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 2.2.2 | Assessment | Not Applicable | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 2.2.3 | Safe restraint use | Not Applicable | 0 | 0 | 0 | 0 | 0 | 6 |
| Standard 2.2.4 | Evaluation | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 2.2.5 | Restraint monitoring and quality review | Not Applicable | 0 | 0 | 0 | 0 | 0 | 1 |
| Standard 2.3.1 | Safe seclusion use |  | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 2.3.2 | Approved seclusion rooms |  | 0 | 0 | 0 | 0 | 0 | 4 |

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| Restraint Minimisation and Safe Practice Standards (of 6): N/A: 5 CI:0 FA: 1 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 21): CI:0 FA:1 PA:0 UA:0 NA: 0 |

1. Infection Prevention and Control

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 3.1 | Infection control management | Not Applicable | 0 | 0 | 0 | 0 | 0 | 9 |
| Standard 3.2 | Implementing the infection control programme | Not Applicable | 0 | 0 | 0 | 0 | 0 | 4 |
| Standard 3.3 | Policies and procedures | Not Applicable | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 3.4 | Education | Not Applicable | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 3.5 | Surveillance | FA | 0 | 2 | 0 | 0 | 0 | 8 |
| Standard 3.6 | Antimicrobial usage |  | 0 | 0 | 0 | 0 | 0 | 5 |

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| Infection Prevention and Control Standards (of 5): N/A: 4 CI:0 FA: 1 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0  Criteria (of 29): CI:0 FA:2 PA:0 UA:0 NA: 0 |

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| **Total Standards (of 50) N/A:** 34 **CI:** 0 **FA:** 8 **PA Neg:** 0 **PA Low:** 5 **PA Mod:** 3 **PA High:** 0 **PA Crit:** 0 **UA Neg:** 0 **UA Low:** 0 **UA Mod:** 0 **UA High:** 0 **UA Crit:** 0  **Total Criteria (of 219) CI:** 0 **FA:** 29 **PA:** 12 **UA:** 0 **N/A:** 0 |

# Corrective Action Requests (CAR) Report

Provider Name: Dixon House Trust Board

Type of Audit: Surveillance audit

Verification audit

Date(s) of Audit Report: Start Date:28-Aug-13 End Date: 28-Aug-13

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXXX

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Std** | **Criteria** | **Rating** | **Evidence** | **Timeframe** |
| 1.1.13 | 1.1.13.3 | PA  Low | **Finding:**  A complaints register is not maintained that records all complaints, management of complaints, response to complainants and outcomes and resolution achieved.  **Action:**  Maintain an up-to-date complaints register. | 3 months |
| 1.2.3 | 1.2.3.1 | PA  Low | **Finding:**  There is not a current quality plan in place in order to provide service direction.  **Action:**  Develop a quality plan that is current and reflects the direction the service wishes to proceed in. | 3 months |
| 1.2.3 | 1.2.3.3 | PA  Low | **Finding:**  Policies and procedures in place were initially developed in 2006. They do not reflect current standards, best practice or contractual requirements  **Action:**  Review the content of all policies and procedures to ensure that they are current and reflect standards, best practice and contractual requirements. | 6 months |

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| 1.2.3 | 1.2.3.6 | PA  Low | **Finding:**  Internal audits are conducted, however, it is noted that audits relating to infection control, medication management, consumer rights, and restraint use have not been conducted and satisfaction surveys have not been conducted for residents and families.  **Action:**  Ensure that all aspects of care and services are audited or surveyed to provide opportunities for improvement. | 6 months |
| 1.2.3 | 1.2.3.8 | PA  Low | **Finding:**  Corrective actions have not been developed in response to identified areas requiring improvement - from audits, complaints, resident meetings, staff meetings.  **Action:**  Develop corrective actions around identified gaps in service or areas requiring improvement. | 6 months |
| 1.2.4 | 1.2.4.3 | PA  Moderate | **Finding:**  a) Previous pressure injuries for two residents were not reported via the incident reporting process; b) Clinical follow up and investigations have not been completed or documented by the registered nurses or manager.  **Action:**  a) Ensure that all adverse events including development of pressure injuries are reported via the incident reporting processes and b) Ensure that there is documented evidence of registered nurse and manager follow up and investigations for all reported incidents. | 1 month |
| 1.2.7 | 1.2.7.5 | PA  Low | **Finding:**  Education relating to elder abuse and neglect, cultural awareness and chemical safety has not been conducted in the past two years.  **Action:**  Provide education and training for staff in areas relating to elder abuse and neglect, cultural awareness and chemical safety. | 6 months |
| 1.3.3 | 1.3.3.1 | PA  Low | **Finding:**  Registered and enrolled nurses complete assessments, care plans and evaluations. There is no evidence of registered nurse oversight of assessments and care plans in three of four files reviewed that have been completed by an enrolled nurse.  **Action:**  Ensure registered nurses complete assessments, care plans and evaluations as per contractual requirements. | 3 months |

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| --- | --- | --- | --- | --- |
| 1.3.12 | 1.3.12.1 | PA  Moderate | **Finding:**  a) Transcribing of medication orders to a 'medication extras' form; b) Administration of controlled drugs not witnessed or signed by two staff members; c) PRN medication orders do not document indications for use in six of eight medication charts; d) Allergies or nil known allergies not recorded on three of eight medication charts; e) Medication reviews conducted outside the three monthly time frame and no documentation to indicate that the resident is stable and can be seen less frequently than monthly.  **Action:**  a) Cease transcribing of medication orders; b) Ensure all controlled drug administration procedures are witnessed by two staff and signed for by two staff; c) Ensure indications for use are documented on PRN medications; d) Record allergies or nil known allergies on medication charts and e) Ensure medication reviews occur in a timely manner as per ARC contract requirements. | Immediately and one month |
| 1.3.12 | 1.3.12.3 | PA  Low | **Finding:**  Medication competencies are not completed for registered nurses and enrolled nurses responsible for medication administration.  **Action:**  Ensure all staff responsible for medication administration are competent to do so. | 3 months |
| 1.3.13 | 1.3.13.1 | PA  Low | **Finding:**  The current four week menu has not been reviewed by a registered dietitian  **Action:**  Ensure that the menu is reviewed by a registered dietitian | 3 months |
| 1.4.2 | 1.4.2.1 | PA  Low | **Finding:**  Fire evacuation drills have not been conducted six monthly.  **Action:**  Ensure that fire evacuation drills are conducted six monthly | 3 months |

# Continuous Improvement (CI) Report

Provider Name: Dixon House Trust Board

Type of Audit: Surveillance audit

Verification audit

Date(s) of Audit Report: Start Date:28-Aug-13 End Date: 28-Aug-13

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXXX

**1. HEALTH AND DISABILITY SERVICES (CORE) STANDARDS**

**OUTCOME 1.1 CONSUMER RIGHTS**

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, facilitates informed choice, minimises harm, and acknowledges cultural and individual values and beliefs.

**STANDARD 1.1.9 Communication**

Service providers communicate effectively with consumers and provide an environment conducive to effective communication.

ARC A13.1; A13.2; A14.1; D11.3; D12.1; D12.3a; D12.4; D12.5; D16.1b.ii; D16.4b; D16.5e.iii; D20.3 ARHSS A13.1; A13.2; A14.1; D11.3; D12.1; D12.3a; D12.4; D12.5; D16.1bii; D16.4b; D16.53i.i.3.iii; D20.3

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🞏 CI 🗷 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

There is an open disclosure policy in place, information on which is included at the time of admission. The policy states residents or their representative have the right to full and open disclosure. Incident and accident forms are completed by either caregivers or registered nurses and a copy of any incident relating to individual residents is included in the clinical file. The family contact sheet records that families are informed following GP review, incidents or accidents or if there is a change in resident condition (confirmed by two relatives interviewed). Notification of next of kin for the July 2013 period of incidents sampled was confirmed through the clinical files reviewed. Copies of completed admission agreements are held in clinical files and an extensive admission booklet is given to all new residents and or family. There is an interpreter policy in place with information included in the admission booklet.

D12.1 Non-Subsidised residents are advised of the process and eligibility to become a subsidised resident through the admission booklet.

D16.1b.ii The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the admission agreement and admission booklet.

D16.4b Residents (eight) and relatives (two) interviewed confirmed they are kept fully informed.

D11.3 The admission booklet is available in large print and can be read to residents if required.

**Criterion 1.1.9.1 Consumers have a right to full and frank information and open disclosure from service providers.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.9.4 Wherever necessary and reasonably practicable, interpreter services are provided.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.13 Complaints Management**

The right of the consumer to make a complaint is understood, respected, and upheld.

ARC D6.2; D13.3h; E4.1biii.3 ARHSS D6.2; D13.3g

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** PA Low

The complaints process and forms for completion are available at the entrance foyer of the facility. Brochures are also freely available for the Health and Disability and advocacy service with contact details provided. A review of complaints received for the past 18 months (four) was conducted. A record of outcomes is recorded, however, a complaints register is not maintained. Improvement is required in this area. Complaints are discussed at the two monthly quality management meetings and the three monthly staff meetings.

D13.3h. A complaints procedure is provided to residents within the information pack at entry.

**Criterion 1.1.13.1 The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.13.3 An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.**

**Audit Evidence** **Attainment:** PA **Risk level for PA/UA:** Low

A review of complaints received for the past 18 months (four) was conducted. A record of outcomes is recorded.

**Finding Statement**

A complaints register is not maintained that records all complaints, management of complaints, response to complainants and outcomes and resolution achieved.

**Corrective Action Required:**

Maintain an up-to-date complaints register.

**Timeframe:**

3 months

**OUTCOME 1.2 ORGANISATIONAL MANAGEMENT**

Consumers receive services that comply with legislation and are managed in a safe, efficient, and effective manner.

**STANDARD 1.2.1 Governance**

The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.

ARC A2.1; A18.1; A27.1; A30.1; D5.1; D5.2; D5.3; D17.3d; D17.4b; D17.5; E1.1; E2.1 ARHSS A2.1; A18.1; A27.1; A30.1; D5.1; D5.2; D5.3; D17.5

Evaluation methods used: D 🗷 SI 🗷 STI 🗷 MI 🞏 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

Dixon House is owned and operated by a combined churches charitable Trust, located in Greymouth. The Dixon House manager reports to the Trust board. The Board secretary advised that the Trust is comprised of representatives of the four churches involved, along with community and clinical representation. The manager has been in the role for 18 months, is a registered nurse with experience in management and mental health. The manager and one RN were absent on the day of the surveillance audit as they were attending an aged care conference. However, the manager was interviewed via telephone. Dixon House is currently certified to provide rest home level care to 37 residents and this audit has verified two studio apartments currently certified for single residents as suitable for double rooms and one room that was previously a lounge as suitable for a rest home level care room. There were 40 residents accommodated on the day of audit. The service has five studio units in an upstairs area which are large enough for married couples. The service is also contracted by the local DHB to provide care for up to six residents with dementia. These residents are assessed as rest home level care but the DHB is funding for extra care staff hours with one to one staffing provided for these six residents during the afternoon/evening period. The Dixon House Trust board has a constitution for organisational governance and direction with a business plan in place. The service has a quality and risk management plan in place. The risk management plan was reviewed in 2013. The quality plan is dated 2010 and includes objectives, policies and procedures, implementation, monitoring, quality risk, and action plan. (link #1.2.3). The mission statement of the organisation is included in the admission documentation.

The manager talks with the board secretary/accountant on a daily basis. The manager reports to the two monthly board meetings on a range of issues including occupancy, staffing, finances, complaints and incidents. There is an audit plan, education plan, incident and accident reporting, with an analysis completed monthly for the three monthly quality meeting.

D17.3di (rest home): The manager has been in the role for 18 months and is a registered nurse, with mental health nursing background and qualifications in health science. The manager was absent on the day of audit, attending an aged care conference.

**Criterion 1.2.1.1 The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.1.3 The organisation is managed by a suitably qualified and/or experienced person with authority, accountability, and responsibility for the provision of services.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.3 Quality And Risk Management Systems**

The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.

ARC A4.1; D1.1; D1.2; D5.4; D10.1; D17.7a; D17.7b; D17.7e; D19.1b; D19.2; D19.3a.i-v; D19.4; D19.5 ARHSS A4.1; D1.1; D1.2; D5.4; D10.1; D16.6; D17.10a; D17.10b; D17.10e; D19.1b; D19.2; D19.3a-iv; D19.4; D19.5

Evaluation methods used: D 🗷 SI 🗷 STI 🗷 MI 🞏 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** PA Moderate

The organisation has quality and risk management policies in place. The Dixon House Trust board has a constitution and a business plan for the service. There is a quality and risk management plan. The risk management plan was reviewed in 2013; the quality plan was last reviewed in 2010. Improvements are required in this area. The risk management plan includes assessment of risk for the organisation which includes emergency planning, adverse events, financial, human resources, clinical, infection control, health and safety and security.

The quality plan for 2010 contains objectives against which results of audits, incident and accident analysis, health and safety, education provided and infection rates are compared. A monthly analysis of all incidents and infection rates is completed and a summary is included in the three monthly quality meeting minutes. Minutes of the quality meeting minutes were viewed for May 2013. Meeting minutes contained matters arising from the previous meeting, occupancy, infection rates, kitchen, staffing, activities, cleaning, education, policies and procedures, resident and staff incidents. The quality management team includes the manager, two registered nurses and administration. Copies of the quality meeting minutes were viewed in a folder available for employees to read. Staff meetings are held three monthly and minutes sighted for April 2013 included discussion around food, laundry, complaints, care planning, communication, and general business.

Policies and procedures reviewed were initially developed in 2006. They have been reviewed and signed off annually - however, content of policies reviewed does not reflect current and relevant standards, contracts and guidelines. Improvements are required in this area. Policy manuals are held in nurse’s stations and in the managers/admin office. Annual satisfaction surveys have not been conducted for residents and relatives. Improvements are required in this area.

An annual audit schedule is implemented (last developed 2011) and audit results for 2013 were viewed. Audits completed and included in the three monthly quality meetings for 2013 relate to nursing and personal cares, clinical waste management, cleaning and laundry, environmental safety, and food storage. Internal audits relating to infection control, medication management, consumer rights, and restraint use have not been conducted and there has been no resident or relative survey. Improvements are required in this area.

Results of audits, incidents and accidents, complaints, and infections are reported to quality management meetings and staff meetings. On review of these items, it was noted that corrective actions are not developed to record how issues are identified and managed. Improvements are required in this area.

D5.4 The service has policies and procedures to support service delivery. However, the content of these policies requires review to ensure that standards and legislative requirements are included.

D10.1 Death/Tangihanga policy and procedure which details action to be taken on a resident’s death with required certifications and documentation. D17.10e: Emergency policies are in place to guide staff in managing clinical and non-clinical emergencies.

D19.3 There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management

D19.2g Falls prevention strategies such as environment review, footwear, use of walking aids, supervision and assistance for residents, the use of sensor pads and falls risk assessments are in place.

D19.3 There is a hazard register that is reviewed annually. Hazard identification forms are completed to identify hazards with actions identified and reviewed/followed up where appropriate.

**Criterion 1.2.3.1 The organisation has a quality and risk management system which is understood and implemented by service providers.**

**Audit Evidence** **Attainment:** PA **Risk level for PA/UA:** Low

The organisation has quality and risk management policies in place. The Dixon House Trust board has a constitution and a business plan for the service. There is a quality and risk management plan. The risk management plan was reviewed in 2013; the quality plan and associated internal audit schedule was last reviewed in 2010 and 2011. The quality plan requires review to ensure that it reflects the current direction of the services.

**Finding Statement**

There is not a current quality plan in place in order to provide service direction.

**Corrective Action Required:**

Develop a quality plan that is current and reflects the direction the service wishes to proceed in.

**Timeframe:**

3 months

**Criterion 1.2.3.3 The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.**

**Audit Evidence** **Attainment:** PA **Risk level for PA/UA:** Low

Policies and procedures reviewed were initially developed in 2006. They have been reviewed and signed off annually - however, content of policies (e.g. medication) does not reflect current and relevant standards, contracts and guidelines.

**Finding Statement**

Policies and procedures in place were initially developed in 2006. They do not reflect current standards, best practice or contractual requirements

**Corrective Action Required:**

Review the content of all policies and procedures to ensure that they are current and reflect standards, best practice and contractual requirements.

**Timeframe:**

6 months

**Criterion 1.2.3.4 There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.3.5 Key components of service delivery shall be explicitly linked to the quality management system.**

This shall include, but is not limited to:

(a) Event reporting;

(b) Complaints management;

(c) Infection control;

(d) Health and safety;

(e) Restraint minimisation.

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.**

**Audit Evidence** **Attainment:** PA **Risk level for PA/UA:** Low

An annual audit schedule is implemented (last developed 2011) and audit results for 2013 were viewed. Audits completed and included in the three monthly quality meetings for 2013 relate to nursing and personal cares, clinical waste management, cleaning and laundry, environmental safety, and food storage.

**Finding Statement**

Internal audits are conducted, however, it is noted that audits relating to infection control, medication management, consumer rights, and restraint use have not been conducted and satisfaction surveys have not been conducted for residents and families.

**Corrective Action Required:**

Ensure that all aspects of care and services are audited or surveyed to provide opportunities for improvement.

**Timeframe:**

6 months

**Criterion 1.2.3.7 A process to measure achievement against the quality and risk management plan is implemented.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.3.8 A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.**

**Audit Evidence** **Attainment:** PA **Risk level for PA/UA:** Low

Results of audits, incidents and accidents, complaints, and infections are reported to quality management meetings and staff meetings. On review of these items, it was noted that corrective actions are not developed to record how issues are identified and managed.

**Finding Statement**

Corrective actions have not been developed in response to identified areas requiring improvement - from audits, complaints, resident meetings, staff meetings.

**Corrective Action Required:**

Develop corrective actions around identified gaps in service or areas requiring improvement.

**Timeframe:**

6 months

**Criterion 1.2.3.9 Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:**

(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;

(b) A process that addresses/treats the risks associated with service provision is developed and implemented.

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.4 Adverse Event Reporting**

All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.

ARC D19.3a.vi.; D19.3b; D19.3c ARHSS D19.3a.vi.; D19.3b; D19.3c

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** PA Moderate

There is incident/accident reporting policies. Adverse events are reported via the incident reporting system with the exception of pressure injuries. Improvements are required in this area. Senior management are aware of the statutory and regulatory obligations regarding essential reporting. Reporting responsibilities are documented. Records were viewed for incident reports completed for July 2013 which included seven falls, and two skin tears. No medication errors were noted. Infections have been recorded and included in quality data and no complaints were received for the month. All incident forms have either been completed by a caregiver or an enrolled nurse. There is an improvement required to ensure that registered nurses conduct and document clinical follow up and that the manager also reviews all incidents for investigations and corrective actions. Corrective actions are included on the incident reporting forms completed by caregivers or enrolled nurses. Resident files reviewed relating to incident forms evidenced documentation of family contact. Eight residents and two relatives interviewed confirmed they are kept fully informed of adverse events as per the open disclosure policy. Copies of relevant incident forms are held in the clinical files. All adverse events are analysed monthly and included in the quality meetings

D19.3c The organisation is aware of their reporting responsibilities to the DHB of any serious accidents or incidents.

D19.3b; There is an incident accident reporting policy which includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action.

**Criterion 1.2.4.2 The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.4.3 The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.**

**Audit Evidence** **Attainment:** PA **Risk level for PA/UA:** Moderate

There is incident/accident reporting policies. Adverse events are reported via the incident reporting system with the exception of pressure injuries. Records were viewed for incident reports completed for July 2013 which included seven falls, and two skin tears. No medication errors were noted. Infections have been recorded and included in quality data and no complaints were received for the month. All incident forms have either been completed by a caregiver or an enrolled nurse. Actions taken are included on the incident reporting forms completed by caregivers or enrolled nurses. Resident files reviewed relating to incident forms evidenced documentation of family contact.

**Finding Statement**

a) Previous pressure injuries for two residents were not reported via the incident reporting process; b) Clinical follow up and investigations have not been completed or documented by the registered nurses or manager.

**Corrective Action Required:**

a) Ensure that all adverse events including development of pressure injuries are reported via the incident reporting processes and b) Ensure that there is documented evidence of registered nurse and manager follow up and investigations for all reported incidents.

**Timeframe:**

1 month

**STANDARD 1.2.7 Human Resource Management**

Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.

ARC D17.6; D17.7; D17.8; E4.5d; E4.5e; E4.5f; E4.5g; E4.5h ARHSS D17.7, D17.9, D17.10, D17.11

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** PA Low

Dixon House has human resource policies and procedures in place which include recruitment, orientation, staff training and industrial relations (these require review as per #1.2.3). Four staff files were viewed covering designations of two caregivers, one enrolled nurse and one registered nurse. The individual files contained a mix of individual and collective contracts, position descriptions outlining responsibilities and expected outcomes, orientation records for the specific roles and performance appraisals signed off by the manager. Records were also viewed of reference checks and completed interview sheets. Copies of current annual practising certificates are held in the individual files. Current annual medication competencies were viewed for two caregivers but not for the enrolled nurse or registered nurse - both of whom are responsible for medication administration. Three of five caregivers interviewed advised that they had completed the ACE qualification and one of five caregivers had completed the national certificate. One of five caregivers has not completed formal training.

The orientation programme includes fire safety, infection control, health and safety and house rules in addition to induction to the role to be undertaken.

An annual in-service training schedule is developed and implemented in addition to the aged care education programme (ACE). Records were viewed for attendance at and assessment of training held for 2012 and 2013 to date. Compulsory attendance is required annually for fire safety, and manual handling. Education for 2013 includes first aid, infection control, ageing process, wound care, dysphagia, restraint, food safety update, medication management, hand washing, residents rights, fire training. In-service training relating to elder abuse and neglect, cultural awareness, continence management and chemical safety has not been conducted in the past two years. Improvements are required in this area. The annual training programme exceeds eight hours annually.

D17.7d: Medication competencies for registered and enrolled nurses have not been conducted (link #1.3.12).

**Criterion 1.2.7.2 Professional qualifications are validated, including evidence of registration and scope of practice for service providers.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.7.3 The appointment of appropriate service providers to safely meet the needs of consumers.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.7.4 New service providers receive an orientation/induction programme that covers the essential components of the service provided.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.**

**Audit Evidence** **Attainment:** PA **Risk level for PA/UA:** Low

An annual in-service training schedule is developed and implemented in addition to the aged care education programme (ACE). Records were viewed for attendance at and assessment of training held for 2012 and 2013 to date. Compulsory attendance is required annually for fire safety, and manual handling. Education for 2013 includes first aid, infection control, ageing process, wound care, dysphagia, restraint, food safety update, medication management, hand washing, residents rights, fire training.

**Finding Statement**

Education relating to elder abuse and neglect, cultural awareness and chemical safety has not been conducted in the past two years.

**Corrective Action Required:**

Provide education and training for staff in areas relating to elder abuse and neglect, cultural awareness and chemical safety.

**Timeframe:**

6 months

**STANDARD 1.2.8 Service Provider Availability**

Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.

ARC D17.1; D17.3a; D17.3 b; D17.3c; D17.3e; D17.3f; D17.3g; D17.4a; D17.4c; D17.4d; E4.5 a; E4.5 b; E4.5c ARHSS D17.1; D17.3; D17.4; D17.6; D17.8

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

There is a documented rostering and skill mix policy in place. A manager is employed for 40 hours per week, two registered nurses work 32 hours and 14 hours respectively. Enrolled nurses are employed across all shifts and there is either a registered or enrolled nurse rostered on every shift. For the morning shift there are five caregivers who work long and short shifts; in the afternoon shift there is either a registered nurse or enrolled nurse with three caregivers working long and short shifts. The service is also contracted to provide care for up to six residents with dementia related needs who are assessed as requiring rest home level care. Two further caregivers are employed specifically for the dementia residents working 3-8pm. On the night shift there is an enrolled nurse and one caregiver.

The roster allows for hand-over time. The rosters provide sufficient and appropriate coverage for effective delivery of care and support for the facility. Further staffing includes cook, kitchen hand, cleaners, activities staff, a mobility coordinator and administration person. Eight residents and two relatives interviewed, confirmed there are sufficient staff on duty to meet their needs.

**Criterion 1.2.8.1 There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.3 CONTINUUM OF SERVICE DELIVERY**

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.

**STANDARD 1.3.3 Service Provision Requirements**

Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals.

ARC D3.1c; D9.1; D9.2; D16.3a; D16.3e; D16.3l; D16.5b; D16.5ci; D16.5c.ii; D16.5e ARHSS D3.1c; D9.1; D9.2; D16.3a; D16.3d; D16.5b; D16.5d; D16.5e; D16.5i

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** PA Low

The registered and enrolled nurses at Dixon House are responsible for development of the care plan with input from caregivers. Assessments are conducted and the initial care plan is developed within 24 hours of admission. Evaluations and reviews are completed by the registered or enrolled nurses six monthly. An improvement is required whereby registered nurses review and sign off all care plans and evaluations as per contractual requirements. Re-assessments are completed at care plan review. The long term care plan is developed within three weeks for four of four care plans reviewed. Assessments include pressure area risk, falls risk, nutrition, pain, behaviour, mobility, continence and social and medical history. Family are, where appropriate, involved from the time of admission and continue to be involved when there is a review of the care plan. Communication with family is documented. A verbal and written handover occurs at the end of each shift. There is also a communication book. Staff are informed of any care plans that have been updated at handover.

Five caregivers interviewed describe a verbal handover at the beginning of each shift where any issues or changes in resident status are discussed. Progress notes are written at least daily. Any issues arising from quality meetings, and resident meetings are communicated to staff. The registered nurses inform staff of any changes to residents' care following visits from the general practitioner or other allied healthcare personnel and also documents this information in residents' progress notes and care plans. Four of four resident files identify integration of allied health personnel and a team approach is evident.

Input from a number of allied health personnel is evident in all four files reviewed including district nurse, GP, physiotherapist, podiatrist, dietitian, palliative care nurse specialist.

Communication with family is documented in the progress notes or on the family contact sheet. There are currently six wounds being managed including two pressure areas. Staff training on wound management has been provided in 2013.

D16.2, 3, 4: Four of four files reviewed identified that an assessment was completed within 24 hours by a registered or enrolled nurse. There are registered or enrolled nurses cover on all shifts.

D16.5e: Four of four resident files reviewed identified that the general practitioner had seen the resident within two working days of admission with three monthly (and as needed) reviews. GP interviewed advised that the staff are prompt to notify him of changes in health status of his residents and that they provide excellent resident centred care.

A range of assessment tools where completed in resident files on admission and completed at least six monthly for all residents including (but not limited to); pressure area risk, weight, skin, continence, falls risk, sleeping, dietary and nutrition, behaviour, mobility and pain.

Four resident files were reviewed..

Tracer Methodology:

*XXXXXX This information has been deleted as it is specific to the health care of a resident.*

**Criterion 1.3.3.1 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function.**

**Audit Evidence** **Attainment:** PA **Risk level for PA/UA:** Low

The registered and enrolled nurses at Dixon House are responsible for development of the care plan with input from caregivers. Assessments are conducted and the initial care plan is developed within 24 hours of admission. Evaluations and reviews are completed by the registered or enrolled nurses six monthly. Re-assessments are completed at care plan review. The long term care plan is developed within three weeks for four of four care plans reviewed. Assessments include pressure area risk, falls risk, nutrition, pain, behaviour, mobility, continence and social and medical history. Family are, where appropriate, involved from the time of admission and continue to be involved when there is a review of the care plan.

**Finding Statement**

Registered and enrolled nurses complete assessments, care plans and evaluations. There is no evidence of registered nurse oversight of assessments and care plans in three of four files reviewed that have been completed by an enrolled nurse.

**Corrective Action Required:**

Ensure registered nurses complete assessments, care plans and evaluations as per contractual requirements.

**Timeframe:**

3 months

**Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.3.4 The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.6 Service Delivery/Interventions**

Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.

ARC D16.1a; D16.1b.i; D16.5a; D18.3; D18.4; E4.4 ARHSS D16.1a; D16.1b.i; D16.5a; D16.5c; D16.5f; D16.5g.i; D16.6; D18.3; D18.4

Evaluation methods used: D 🞏 SI 🞏 STI 🞏 MI 🞏 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

Four of four care plans viewed are completed comprehensively. The care being provided is consistent with the needs of residents, this is evidenced by discussions with the GP, one clinical nurse specialist, five care givers, one enrolled nurse, one registered nurse, eight residents and two family members. Care plans include the following sections: communication, nutrition, mobility, hygiene, cognition, elimination, activities of daily living, skin integrity, pain, rest/sleep, and spiritual/cultural. Medical profiles are completed by the GP's. Residents with dementia and/or challenging behaviours have comprehensive behaviour management plan in place. Short-term care plans are used for acute or short-term changes in health status as evidence in two files - UTI, pressure area care and wound care.

Residents are needs assessed prior to admission and have the services of their own GP. There is evidence of referrals to specialist services such as palliative care, clinical nurse specialist, dietitian, physiotherapist, podiatry. The service could describe links with other services such as the hospice, needs assessment and other services working with residents. Six residents at Dixon House received extra care and support under a DHB contract. The residents have dementia care needs (but are assessed as requiring rest home level care) and have care plans designed for their safety. One resident has a Wanda-track device and a plan in place if the resident leaves the facility. An Alzheimer's search and rescue profile has been developed and staff are vigilant at supervising his whereabouts. He lives in an upstairs apartment with his wife and is currently settled. There has been one incident of the resident leaving the facility soon after admission, however, this has not reoccurred.

The facility has an RN manager who works full time, and two registered nurses who work 32 hours and 14 hours respectively. The manager and one RN were absent on the day of the surveillance audit. Enrolled nurses work across all shifts. Needs are assessed using pre admission documentation, doctors notes, and the assessment tools which are completed by the registered and enrolled nurses. Reviewing and signing off of assessments and care plans is required by a registered nurse (link #1.3.3). Care plans are goal oriented and reviewed at least six monthly for all residents. During the tour of facility it was noted that all staff treated residents with respect and dignity, residents and families were able to confirm this observation. There is a programme of activities in place and residents are able to access the community and associated services and support. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. All four files reviewed contained continence management interventions documented in the resident's care plans. Specialist continence advice is available as needed and this could be described by staff.

D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use.

Continence management in-services have not been provided in the past two years (link #1.2.7) however, wound management in-service has been conducted in 2013. Wound specialist input is sought from the district nursing service.

Wound assessment and wound management plans are in place for six residents with wounds - two pressure areas, three leg ulcers and one skin lesion. The registered nurse interviewed described the referral process and related form should they require assistance from a wound specialist or continence nurse. One resident with a complex wound has input from local district nursing service.

**Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.7 Planned Activities**

Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.

ARC D16.5c.iii; D16.5d ARHSS D16.5g.iii; D16.5g.iv; D16.5h

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🞏 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

There is an activities coordinator who works Monday to Friday, a mobility coordinator who works Mondays, Wednesdays and Fridays, and the maintenance person also assists with activities including outings and van rides. The activities coordinator was absent on the day of audit. The mobility coordinator was interviewed and advised that she takes the exercise classes with residents and assists residents to improve mobility and strength for falls prevention. Exercise activity was observed in progress. Caregivers also assist with activities as evidenced in the afternoon of audit. The activities programme is developed by the activities coordinator with input from staff and residents. On admission an activity social profile documenting residents social history, likes and dislikes and past and present interests is completed. The individual recreation plan is completed within three weeks and reviewed at care plan review. Residents are able to participate in an exercise programme, housie, one to one time, music and entertainment, weekly Chapel services, outings, various games, reminiscing, happy hour, manicures, visiting entertainers, seasonal celebrations, shopping, crosswords, quizzes, newspaper reading, bowls, and other activities to maintain strength and interests. Participation in activities is voluntary. Activities were observed in progress during the audit. Advised by a visiting chaplain that the four churches involved in the service provide in-house church services for residents.

The activities programme is developed monthly and covers five days per week. The activities staff have current drivers licences and current first aid certificates. The weekly programme is displayed on a white board. Four resident files reviewed contain an assessment, goals and an activities support plan. Eight residents interviewed are satisfied with the programme, and find it varied, enjoyable and fun. Activities take place in either the dining or lounge areas and there is a further smaller lounge for private gatherings and church services. Residents are able to provide feedback and suggestions for activities at the resident meetings which are held quarterly.

Six residents at Dixon House have identified dementia care needs. The DHB have contracted the service to continue to care for the residents with input from extra designated caregivers in the afternoon. Activities for these residents are designed specifically and include diversional therapies. One of four files reviewed (dementia care) evidenced comprehensive behaviour management and activities plans. Caregivers interviewed they have activities available over a 24 hour period if these are required such as television. puzzles and board games.

D16.5d Four of four resident files reviewed identified that the individual activity plan is reviewed when at care plan review.

**Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.8 Evaluation**

Consumers' service delivery plans are evaluated in a comprehensive and timely manner.

ARC D16.3c; D16.3d; D16.4a ARHSS D16.3c; D16.4a

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

Long term care plans are evaluated six monthly for all residents as evidenced by six of six care plans reviewed by the registered nurses and enrolled nurses with input from care givers, residents and family (link #1.3.3). A review of four long term care plans and discussions with one RN, one EN, five caregivers, eight residents and two families, confirm that this is the case. On review of care plans, it was noted that each individual aspect of the care plan is evaluated. GP advised that she conducts three monthly clinical and medication reviews and as required. (this was not evidenced in four of eight medication charts reviewed link #1.3.12). Short term care plans are utilised for issues such as wounds, and infections, and registered and enrolled nurses sign and date the short term care plans when the issue/problem has been resolved. Wound care plans document and describe the wounds progress.

D16.4a Care plans are evaluated six monthly for all residents or more frequently when clinically indicated.

D16.3c: Initial care plans are evaluated by a registered or enrolled nurse within three weeks of admission in four of four care plans reviewed (link finding #1.3.3). The long term care plan is developed within three weeks of admission in four of four care plans reviewed.

**Criterion 1.3.8.2 Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.8.3 Where progress is different from expected, the service responds by initiating changes to the service delivery plan.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.12 Medicine Management**

Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.

ARC D1.1g; D15.3c; D16.5e.i.2; D18.2; D19.2d ARHSS D1.1g; D15.3g; D16.5i..i.2; D18.2; D19.2d

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🞏 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** PA Moderate

The service uses four weekly Medico/Douglas packs for the administration of medications at Dixon House. Eight medication charts were reviewed and all medication charts have photo ID’s. There is a signed agreement with the pharmacy. Blistered medications are checked on arrival by the registered nurse, a verification form is completed and signed and any pharmacy errors recorded and fed back to the supplying pharmacy. The medication trolley is locked and stored in the nurses stations when not in use. Extra medications are stored in a locked cupboard. Staff sign for the administration of medications on medication sheets held with the medicines. The medication folder has a list of specimen signatures and competencies are completed annually for caregivers but not for registered or enrolled nurses. Improvements are required in this area.

Controlled medications are stored in a locked safe in the nurses’ station. A controlled drug register for the safekeeping and administration of controlled drugs is maintained. These drugs are checked on arrival, weekly and on administration. Two staff check and sign for controlled drugs. The registered nurses, enrolled nurses and medication competent caregivers are responsible for administration of medications. There is no documented medication competency for registered and enrolled nurses and this is an area requiring improvement. Eight medication charts reviewed evidenced that there were no gaps on medication signing sheets. Reasons for not giving were noted such as 'refused' or 'withheld'. Medication management audits have not been conducted (link #1.2.3). Medication errors are identified via the incident reporting system. The facility has a policy on self-administration of medications. There are currently no residents self-administering medications at Dixon House. The service has in place policies and procedures for medication management, however, these require review (link #1.2.3) to ensure policies align with current guidelines. On review of eight resident files, it was noted that transcribing of medication orders has occurred on to a 'medication extras' form. This is a reminder sheet for staff for non-packaged medications. This is an area requiring improvement. On observing the morning medication round, it is noted that two staff are not signing the controlled drug administration sheet or witnessing the resident take the medication or that a controlled drug medication patch is applied. Six of eight medication charts evidence that PRN medications do not have documented indications for use. Allergies or nil known allergies are not recorded on three of eight medication charts. Medication reviews conducted by the GP's are outside the three monthly time frame in four of eight charts reviewed. There is no documentation from the GP's to indicate that the residents are stable and can be seen three monthly as per ARC contract. Improvements are required in these areas. Medication management education session was provided in March 2013 with nine attendees.

D16.5.e.i.2; Eight medication charts were reviewed. Four charts identified that the GP had reviewed the resident three monthly and the medication chart was signed. Four charts evidenced that medication reviews were conducted outside the three month time frame.

**Criterion 1.3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.**

**Audit Evidence** **Attainment:** PA **Risk level for PA/UA:** Moderate

The service uses four weekly Medico/Douglas packs for the administration of medications at Dixon House. Eight medication charts were reviewed and all medication charts have photo ID’s. There is a signed agreement with the pharmacy. Blistered medications are checked on arrival by the registered nurse, a verification form is completed and signed and any pharmacy errors recorded and fed back to the supplying pharmacy. The medication trolley is locked and stored in the nurses stations when not in use. Extra medications are stored in a locked cupboard. Staff sign for the administration of medications on medication sheets held with the medicines. The medication folder has a list of specimen signatures and competencies are completed annually for caregivers but not for registered or enrolled nurses. Improvements are required in this area.

Controlled medications are stored in a locked safe in the nurses’ station. A controlled drug register for the safekeeping and administration of controlled drugs is maintained. These drugs are checked on arrival, weekly and on administration. Two staff check and sign for controlled drugs. The registered nurses, enrolled nurses and medication competent caregivers are responsible for administration of medications. Eight medication charts reviewed evidenced that there were no gaps on medication signing sheets. Reasons for not giving were noted such as 'refused' or 'withheld'.

**Finding Statement**

a) Transcribing of medication orders to a 'medication extras' form; b) Administration of controlled drugs not witnessed or signed by two staff members; c) PRN medication orders do not document indications for use in six of eight medication charts; d) Allergies or nil known allergies not recorded on three of eight medication charts; e) Medication reviews conducted outside the three monthly time frame and no documentation to indicate that the resident is stable and can be seen less frequently than monthly.

**Corrective Action Required:**

a) Cease transcribing of medication orders; b) Ensure all controlled drug administration procedures are witnessed by two staff and signed for by two staff; c) Ensure indications for use are documented on PRN medications; d) Record allergies or nil known allergies on medication charts and e) Ensure medication reviews occur in a timely manner as per ARC contract requirements.

**Timeframe:**

Immediately and one month

**Criterion 1.3.12.3 Service providers responsible for medicine management are competent to perform the function for each stage they manage.**

**Audit Evidence** **Attainment:** PA **Risk level for PA/UA:** Low

The medication folder has a list of specimen signatures and competencies are completed annually for caregivers

**Finding Statement**

Medication competencies are not completed for registered nurses and enrolled nurses responsible for medication administration.

**Corrective Action Required:**

Ensure all staff responsible for medication administration are competent to do so.

**Timeframe:**

3 months

**Criterion 1.3.12.5 The facilitation of safe self-administration of medicines by consumers where appropriate.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.12.6 Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.13 Nutrition, Safe Food, And Fluid Management**

A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.

ARC D1.1a; D15.2b; D19.2c; E3.3f ARHSS D1.1a; D15.2b; D15.2f; D19.2c

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** PA Low

Dixon House has a large well equipped kitchen. All food is cooked on site. There is a food services manual that ensures that all stages of food delivery to the resident is noted and documented and complies with standards legislation and guidelines. A tour of the kitchen noted cleanliness and order in the pantry and fridges complying with guidelines. The service employs cooks and kitchen hands. The head cook has completed unit standards 167 and all kitchen staff have completed food safety training, and infection prevention education.

All fridges and freezer temperatures are recorded daily on the recording sheet which was sighted. Food temperatures are recorded daily. Dish washer temperature is recorded daily. Dry food stuffs are stored in a storage area in the kitchen. All food was covered and stored on shelving above floor level.

A nutritional profile for each resident is completed on admission and updated as required. Individual likes and dislikes, allergies, meal size and portions, are recorded on a white board. There are meal options for diabetic, pureed, soft, thickened fluids and special dietary needs. There is a dietitian available for individual resident need. The menu is designed by the cook, however, this has not been reviewed by a registered dietitian. Improvement is required in this area. Diets are modified as required. Staff were observed assisting residents with meals and drinks. Eight residents interviewed were very complimentary about the food provided and like the variety of the menu. Weights are monitored monthly or more frequently if indicated. Residents with weight loss issues receive nutritional supplements and food intake is monitored when required.

D19.2 staff have been trained in safe food handling and a food safety update was provided in March 2013.

**Criterion 1.3.13.1 Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.**

**Audit Evidence** **Attainment:** PA **Risk level for PA/UA:** Low

A nutritional profile for each resident is completed on admission and updated as required. Individual likes and dislikes, allergies, meal size and portions, are recorded on a white board. There are meal options for diabetic, pureed, soft, thickened fluids and special dietary needs. There is a dietitian available for individual resident need. The menu is designed by the cook. Diets are modified as required. Staff were observed assisting residents with meals and drinks.

**Finding Statement**

The current four week menu has not been reviewed by a registered dietitian

**Corrective Action Required:**

Ensure that the menu is reviewed by a registered dietitian

**Timeframe:**

3 months

**Criterion 1.3.13.2 Consumers who have additional or modified nutritional requirements or special diets have these needs met.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.13.5 All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 1.4 SAFE AND APPROPRIATE ENVIRONMENT**

Services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensures 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.

These requirements are superseded, when a consumer is in seclusion as provided for by of NZS 8134.2.3.

**STANDARD 1.4.2 Facility Specifications**

Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.

ARC D4.1b; D15.1; D15.2a; D15.2e; D15.3; D20.2; D20.3; D20.4; E3.2; E3.3e; E3.4a; E3.4c; E3.4d ARHSS D4.1c; D15.1; D15.2a; D15.2e; D15.2g; D15.3a; D15.3b; D15.3c; D15.3e; D15.3f; D15.3g; D15.3h; D15.3i; D20.2; D20.3; D20.4

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🞏 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** PA Low

Dixon House provides a safe, secure and appropriate environment for the care of older persons with rest home level needs. The service has a current building warrant of fitness (WOF) dated 1 Julyv2014. Fire alarms and sprinkler systems are maintained and are checked monthly. There is an approved fire evacuation scheme. Fire evacuation drill was last conducted on 12 February2013. An improvement is required to ensure that fire drills are conducted six monthly. There is evidence that the maintenance personnel carries out regular and reactive maintenance. All electrical equipment and other machinery is checked as part of the annual maintenance checks. There are policies relating to provision of equipment, furniture and amenities. Residents bring their own possessions into the home and these are evident in their rooms. Eight residents and two family members interviewed stated that they were happy with the resident's surroundings and appreciated the residents having personal items and belongings about them. The facility has pleasant comfortable furniture that is designed for the elderly resident. Fixtures and fittings are appropriate and meet the needs of the residents. All floor surfaces are of modern material that can be cleaned. Wet areas in bathrooms are covered in modern slip resistance vinyl’s. There are hand rails and ramps as appropriate. All areas of the facility have suitable easy clean surfaces. Corridors are spacious and allow free movement around the facility with mobility aids where required. Gardens and outside areas are accessible to residents. There are outdoor tables and chairs for resident to sit and a shaded area if required. Chemicals are stored securely.

The service is using two studio apartments currently certified for single residents for double rooms and one room that was previously a lounge for rest home level care. These rooms are verified as suitable and appropriate for these purposes.

D15.3: The following equipment is available, pressure relieving mattresses, shower chairs, standing and sling hoists, heel protectors, lifting aids.

**Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.**

**Audit Evidence** **Attainment:** PA **Risk level for PA/UA:** Low

The service has a current building warrant of fitness (WOF) dated 1 Jluy2014. Fire alarms and sprinkler systems are maintained and are checked monthly. There is an approved fire evacuation scheme. Fire evacuation drill was last conducted on 12 February2013.

**Finding Statement**

Fire evacuation drills have not been conducted six monthly.

**Corrective Action Required:**

Ensure that fire evacuation drills are conducted six monthly

**Timeframe:**

3 months

**Criterion 1.4.2.4 The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.4.2.6 Consumers are provided with safe and accessible external areas that meet their needs.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**2. HEALTH AND DISABILITY SERVICES (RESTRAINT MINIMISATION AND SAFE PRACTICE) STANDARDS**

**OUTCOME 2.1 RESTRAINT MINIMISATION**

**STANDARD 2.1.1 Restraint minimisation**

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🞏 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

There is a restraint policy which requires review (link #1.2.3). One registered nurse is the restraint coordinator. There are no residents requiring restraint or enablers. There is a documented definition of restraint and enablers. Staff have received education on restraint minimisation and challenging behaviour management in March 2013. On interview, one registered nurse, one enrolled nurse and five care givers were knowledgeable about restraint minimisation and alternatives and in managing challenging behaviours. Restraint minimisation and challenging behaviour management is also part of the ACE training programme provided at Dixon House.

**Criterion 2.1.1.4 The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**3. HEALTH AND DISABILITY SERVICES (INFECTION PREVENTION AND CONTROL) STANDARDS**

**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.

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🞏 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

The infection prevention and control policy describes and outlines the purpose and methodology for the surveillance of infections. An enrolled nurse is the infection control nurse for Dixon House. Information obtained through surveillance is used to determine infection control activities, resources, and education needs within the facility. There is close liaison with the GP's and laboratory that advise and provide feedback /information to the service.

Systems in place are appropriate to the size and complexity of the facility. A monthly infection report is compiled. Advised that infection surveillance information is recorded when signs and symptoms of infection have been identified. Infection control data is collated monthly and reported to three monthly quality management meetings and three monthly staff meetings. All infections recorded are documented on the monthly infection summary. Documentation covers a summary, investigation, evaluation and action taken. Infection control audits are conducted as part of the clinical waste management audit, the food storage audit and the nursing and personal cares audit (last conducted May 2013). Results of surveillance and audits are communicated to staff via staff meetings, at handover time and via information and graphs posted in the staff room. Education for staff is provided by the infection control nurse from the local DHB.

**Criterion 3.5.1 The organisation, through its infection control committee/infection control expert, determines the type of surveillance required and the frequency with which it is undertaken. This shall be appropriate to the size and complexity of the organisation.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 3.5.7 Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**