# Dixon House Trust Board - Dixon House Rest Home

## Introduction

This report records the results of a Certification Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Dixon House Trust Board

**Premises audited:** Dixon House Rest Home

**Services audited:** Rest home care (excluding dementia care)

**Dates of audit:** Start date: 17 October 2016 End date: 18 October 2016

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

**Total beds occupied across all premises included in the audit on the first day of the audit:** 37

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

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

## General overview of the audit

Dixon House is governed by the Greymouth Combined Churches Community Trust Board. The service is certified to provide rest home level care for up to 37 residents with 37 residents accommodated on the days of audit. The facility manager is a registered nurse who has been in the role for four years. Family and residents interviewed spoke positively about the care and support provided.

The certification audit was conducted against the Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management and staff. The manager is supported by registered and enrolled nurses and care staff.

The certification audit identified that improvements are required in relation to corrective actions, analysis of quality data, incident reports, staff files, care planning, care interventions, care plan reviews, medication management, and hot water temperatures.

## Consumer rights

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

Dixon House provides care in a way that focuses on the individual resident. Cultural and spiritual assessment is undertaken on admission and during the review processes. Policies are implemented to support individual rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. Information about the Code and related services is readily available to residents and families. Complaints processes are implemented and managed in line with the Code. Residents and family interviewed verified ongoing involvement with community.

## Organisational management

|  |  |  |
| --- | --- | --- |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

Dixon House has a document quality and risk management system. Quality data is gathered on infection control, internal audits, concerns and complaints and surveys.

There are human resources policies and processes available. The service has an orientation programme that provides new staff with relevant information for safe work practice. There is an education programme covering relevant aspects of care and external training is supported. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

## Continuum of service delivery

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

Service information is provided to residents and family on admission to services. Resident records reviewed provide evidence that the registered nurses utilise InterRAI and paper based assessments to assess residents. Care plans are developed in consultation with the resident and/or family. Care plans demonstrate service integration and are reviewed at least six monthly. Resident files include three monthly reviews by a general practitioner. There is evidence of other allied health professional input into resident care.

Medication policies reflect legislative requirements and guidelines and medications are recorded using paper based system. All staff responsible for administration of medicines completes education and medicines competencies. The medicines records reviewed include documentation of allergies and sensitivities and are reviewed at least three monthly by the general practitioner.

A varied activities programme is in place for the rest home and dementia residents. The programme includes community visitors and outings, entertainment and activities that meet the recreational preferences and abilities of the residents.

The menu is designed and reviewed by a registered dietitian and all meals are cooked on site. Residents' individual needs are identified. There is a process in place to ensure changes to residents’ dietary needs are communicated to the kitchen.

## Safe and appropriate environment

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| --- | --- | --- |
| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | Some standards applicable to this service partially attained and of low risk. |

The service displays a current building warrant of fitness. Furniture and fittings are selected with consideration to residents’ abilities and functioning. Residents can and do bring in their own furnishings for their rooms. The service has policies and procedures for management of waste and hazardous substances and incidents are reported on in a timely manner. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances. Documented policies and procedures for the cleaning and laundry services are implemented with monitoring systems in place to evaluate the effectiveness of these services. Policies and procedures are in place for essential, emergency and security services, with adequate supplies should a disaster occur. There are staff on duty with a current first aid certificate.

## Restraint minimisation and safe practice

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

Restraint minimisation is practiced and overseen by the manager. There are no residents using enablers or restraints.

## Infection prevention and control

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

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The registered nurse is the infection control coordinator. There is a suite of infection control policies and guidelines that meet infection control standards. Staff receive annual infection control education. Surveillance data is collected and collated.

## Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 37 | 0 | 2 | 5 | 1 | 0 |
| **Criteria** | 0 | 84 | 0 | 4 | 4 | 1 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | Dixon House has policies and procedures that align with the requirements of the Code of Health and Disability Services Consumer Rights (the Code). Four caregivers, an activities person, two registered nurses (RN), one enrolled nurse and the manager were able to describe how they incorporate resident choice into their activities of daily living. The service actively encourages residents to have choices and this includes voluntary participation in daily activities as confirmed on interview with seven residents. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | The service has policies and procedures relating to informed consent and advanced directives. All seven files reviewed included signed informed consent forms and advanced directive instructions. Staff are aware of advanced directives. Admission agreements were sighted which were signed by the resident or nominated representative. Discussion with residents and families identified that the service actively involves them in decision making. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Advocacy information is available to residents in the service entrance. Interviews with residents and family confirmed they were aware of their right to access advocacy.  Residents confirm that the service provides opportunities for the family/EPOA to be involved in decisions. The resident files sampled included information on the residents’ family. Staff training in code of rights and advocacy has been provided. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | Interview with residents confirm relatives and friends can visit at any time and are encouraged to be involved with the service and care. Residents are encouraged, wherever possible, to maintain former activities and interests in the community. They are supported to attend community events, clubs and interest groups in the community. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | There is a complaints policy to guide practice which aligns with Right 10 of the Code. The manager leads the investigation of concerns/complaints. Complaints forms are visible and available for relatives/residents. A complaints procedure is provided to residents within the information pack at entry. The complaints file was reviewed. There is an up-to-date complaints register. Two complaints from 2016 were reviewed and all document that appropriate and timely responses have been recorded. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | There is a welcome pack provided to residents on entry that includes information on how to make a complaint, Code of Rights pamphlet, advocacy and Health & Disability (HDC) Commission. Relatives and residents are informed of any liability for payment of items not included in the scope of the service. This is included in the service agreement. Residents and three family members interviewed confirmed they received all the relevant information during admission. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | There are policies in place to guide practice in respect of independence, privacy and respect. Resident preferences are identified during the admission and care planning process with family involvement. Staff were observed to be respectful of residents’ personal privacy by knocking on doors prior to entering resident rooms during the audit. Residents interviewed confirmed staff respect their privacy, and support residents in making choices as able. Staff have completed education around privacy, dignity and elder protection.  Resident files are stored securely. There are clear instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | There is a Māori health plan and a cultural safety policy that includes a description of how they will achieve the requirements set out in A3.1 (a) to (e). Residents who identify as Māori have this identified in the care plan. Linkages with Māori community groups are available and accessed as required. Staff receive education on cultural awareness during their induction to the service and as a regular in-service topic. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | Care plans sampled included the residents’ values, spiritual and cultural beliefs. Discussion with family and residents confirm values and beliefs are considered. Residents are supported to attend church services of their choice. Spiritual care is a central component of the care provided at Dixon House. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Job descriptions include responsibilities of the position and are in place for all roles within the service. The RNs and allied health professionals practice within their scope of practice. Management and staff meetings include discussions on professional boundaries and concerns/complaints as they arise. Interviews with the registered nurses and care staff confirmed an awareness of professional boundaries. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | There are policies and procedures in place that meet the health and disability safety sector standards. Staff state they are made aware of new/reviewed policies. Staff report the manager is approachable and supportive. Allied health professionals are available to provide input into resident care. Staff complete relevant workplace competencies. Discussions with residents and family were positive about the care they receive. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | There is a policy to guide staff on the process around open disclosure. The staff and relatives interviewed confirm family are kept informed. Relatives stated they are notified promptly of any incidents/accidents and the manager is very approachable. Resident meetings are held. Newsletters from the service ensure that families are updated regarding service changes.  There is access to an interpreter service as required. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Dixon House is owned and operated by a combined churches charitable trust. The Dixon House manager reports monthly to the trust board. The manager is a registered nurse and has been in the role for over four years. Dixon House is certified to provide rest home level care to 37 residents with 37 residents accommodated on the day of audit. All residents are under the age related contract. There were no respite residents.  The service is also contracted by the local DHB to provide care for up to six residents with diagnoses of dementia. There are currently four residents under this contract at Dixon House. These residents are assessed as rest home level care with DHB funding for extra care staff hours. This includes one staff member allocated to provide care and activities for these four residents during the afternoon/evening period (link high risk finding 1.3.6.1).  The Dixon House trust board has a constitution for organisational governance and direction with a business plan in place. The service has a quality management system with associated policies and procedures in place and with assistance provided from an external consultant. There is a quality and risk management plan in place. The quality plan includes objectives, policies and procedures, implementation, monitoring, quality risk, and action plan.  The facility manager has maintained at least eight hours of professional development in the past 12 months. |
| Standard 1.2.2: Service Management  The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | The quality coordinator (registered nurse) provides cover in the absence of the manager. |
| 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. | PA Moderate | Dixon House has a quality and risk programme which has been provided, and is updated, by an external consultant. A quality coordinator/registered nurse is responsible for the quality programme, along with the manager. Quality activities include internal audits, resident and family surveys and collection of infection rates, and incident and accident data. Not all information collected has been analysed or collated.  There are policies and procedures available which have been provided by the external consultant. Staff confirmed they are made aware of any new/reviewed policies.  There is a business plan and a quality and risk management plan for 2016 in place. Annual review of the 2015 programme has been completed. Progress with the quality and risk management programme is monitored through the quality assurance meeting. Staff have access to meeting minutes. Staff and resident meetings are held. Not all minutes of meetings include actions to achieve compliance where relevant. Discussions with the manager and staff confirm their involvement in the quality programme. There is an implemented internal audit schedule in place for 2016. The resident and relative survey has been completed in October 2016. Results from these are in the process of being collated.  There is a health and safety and risk management system in place including policies to guide practice. The quality coordinator and a designated caregiver are responsible for health and safety. There is a current hazard register. Staff confirm they are kept informed on health and safety matters.  Falls prevention strategies are implemented for individual residents and staff receive training to support falls prevention. |
| 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. | PA Moderate | Seventeen accident/incident forms for August and September 2016 were sampled. Not all incident forms documented RN review of the incident and opportunities to minimise further risk (also link to 1.3.6.1 for neurological observations and issues identified in progress notes). Accidents/incidents were recorded in the resident progress notes, and changes made to care plan documentation as needed. There is documented evidence the family had been notified promptly of accidents/incidents.  Discussions with the manager confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications. |
| 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. | PA Moderate | There are human resources policies to support recruitment practices. Six staff files sampled contained all relevant employment documentation for a cook, one registered nurse, one enrolled nurse, an activities person and two caregivers. Current practising certificates were sighted for the registered nurses. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed believed new staff were adequately orientated to the service on employment. Not all staff files reviewed evidenced completed employment documentation.  There is an education planner in place that covers compulsory education requirements. The programme provided is comprehensive. Two registered nurses have completed InterRAI training. Clinical staff complete competencies relevant to their role. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. A roster provides sufficient and appropriate coverage for the effective delivery of care and support. The manager is on-site full time and available after hours. There is either a registered or enrolled nurse on every shift. The caregivers, residents and family interviewed inform there are sufficient staff on duty at all times. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The resident files are appropriate to the service type. All relevant initial information is recorded within required timeframes into the resident’s individual record. All resident records containing personal information is kept confidential. Entries were legible, dated and signed by the relevant caregiver or registered nurse including designation. Files are integrated. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | There is a policy in place to guide resident admissions. The service communicates with needs assessors and other appropriate agencies prior to the resident’s admission regarding the level of care requirements. There is an information pack provided to all residents and their families on services available. Residents and/or family/whānau are provided with associated information (eg, information on their rights, the Code, complaints management, advocacy, and the admission agreement). Family members and residents interviewed stated that they had received the information pack and had received sufficient information prior to and on entry to the service. Signed admission agreements were evidenced on seven resident files reviewed. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | The service has transfer and discharge procedures. The procedures include a transfer/discharge form and the completed form is placed on file and retained as part of the archived resident records. |
| 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. | PA Low | The service uses a four-weekly blister pack system for tablets and other medicines are pharmacy packaged. All medicines are stored securely when not in use. The medication fridge had temperatures recorded daily and these are within acceptable ranges, however out of date medication was stored in the fridge.  A verification check is completed by the RN against the resident’s medicine order when new medicines are supplied from the pharmacy. Medication orders include indications for use of ‘as required’ medicines. Education on medication management has occurred with competencies conducted for the registered nurse and senior caregivers with medication administration responsibilities. Administration sheets are appropriately signed. Fourteen medication charts reviewed (including four for resident at rest home level with additional dementia funding) identified that the GP had seen the resident three monthly and the medication chart was signed each time a medicine was administered by staff. One RN was observed administering medications and followed correct procedures. One resident self-administers medicines. They have access to secure storage in their rooms and the GP has reviewed the competency three monthly. Residents/relatives interviewed stated they are kept well informed of any changes to their medications. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | Dixon House has a fully equipped kitchen and all food is cooked on site. There are three cooks and two kitchen hands. All kitchen staff have completed food safety training. There is a four-weekly rotating menu. The menu is reviewed by a dietitian annually. A food services manual is available that ensures that all stages of food delivery to the resident are documented and comply with standards, legislation and guidelines. All fridges and freezer temperatures are recorded daily on the recording sheet sighted. Food temperatures are recorded daily. All food is served hot directly from the oven and oven top from food preparation containers to residents in the dining room or to their rooms as required.  The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. This is reviewed six monthly as part of the care plan review. Changes to residents’ dietary needs are communicated to the kitchen as reported by the cook interviewed.  Residents report satisfaction with food choices, and meals are well presented. Relatives interviewed report that their relatives are very happy with the meals. There is homemade baking for morning and afternoon tea. Alternative meals are offered as required and individual resident likes and dislikes are noted on a noticeboard in the kitchen. There is a cleaning schedule, which is signed by member of staff completing cleaning tasks. |
| Standard 1.3.2: Declining Referral/Entry To Services  Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | The service has a process for declining entry should this be necessary. This includes informing persons and referrers (as applicable) the reasons why the service has been declined. Management have not had to decline entry to prospective rest home residents. The reason for declining service entry to potential residents would be recorded and communicated to the potential resident/family/whānau and alternative options suggested if appropriate. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | InterRAI assessments and assessment summaries were evident in printed format in all files. Comprehensive paper based assessments were reflected into all seven resident files reviewed (link to 1.3.5.2 for InterRAI assessments and lack of links to care plans). All resident files included an up-to-date InterRAI assessment. Pain assessments were evidenced as completed with ongoing monitoring recorded, for residents requiring administration of controlled medication as part of prescribed pain management plan. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Moderate | The service utilise a range of paper based assessments to develop the long-term care plans. All residents had an InterRAI assessment. Resident long-term care plans were individually developed with the resident and/or family/whānau. Residents and family members interviewed stated they are involved in the care planning process.  Resident long-term care plans reviewed did not all reflect the InterRAI assessment. Care plan gaps included some areas of the template left blank and interventions for areas of identified risk did not include all interventions to guide staff.  Activities care plans were completed for all files reviewed. Residents are seen by the GP at least three monthly or more frequently if required. The GP records progress in the medical records and notes reviews on the resident’s medicine management charts. Short-term care plans are in use. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA High | The care being provided for residents is not fully consistent with the needs of the residents, as evidenced through review of resident files, interviews with staff and observation of practice. The service is also contracted by the local DHB to provide care for up to six residents with diagnoses of dementia. There are currently four residents under this contract at Dixon House. Not all residents under this dementia top-up contract are receiving care and service consistent with their assessed risks. These residents are assessed as rest home level care with DHB funding for extra care staff hours. This includes one to four staffing provided for these four residents during the afternoon/evening period.  Residents who required registered nurse review following health concerns do not always have this recorded as having been done. Registered nurse input into progress notes was not evident with issues identified through caregiver progress notes entries. Relatives were notified of changes in a resident's condition as evidenced in progress notes, incident reports and family contact sheets. Caregivers document any changes in care/condition of residents in the progress notes. The resident care plans and records reviewed were not fully completed (link 1.3.5.2 and 1.3.8.3). All residents interviewed reported satisfaction with the care and service delivery.  Wound assessments, wound management plans, short-term care plans and wound progress reports were not fully completed for all residents with wounds. There were adequate dressing and continence supplies sighted on the day of audit. |
| 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. | FA | The service employs a qualified diversional therapist (DT) 20 hours a week. The DT is responsible for the planning and delivery of the activities programme with assistance from the manager and care staff. The DT has over eight years’ experience working in aged care. There are currently four residents who are assessed as rest home level care but who have diagnoses of varying degrees of dementia. The service receives extra funding for afternoon and evening activities which are provided by caregivers. The diversional therapist has provided a separate activities document to assist caregivers with the provision of activities for these residents. Caregivers document on each shift what activities these residents have engaged in.  Activities are provided in the large communal lounge/dining room, in seating areas including a computer area, gardens (when weather permits) and one-on-one input in resident’s rooms when required. On the days of audit residents were observed being actively involved with a variety of activities including story reading/discussions, church service and one-on-one input. The activities programme is developed monthly and a copy of the programme is available in the lounge, on noticeboards and in each resident room. Residents have an initial assessment completed over the first few weeks after admission obtaining a complete social history of past and present interests and life events.  The programme includes residents being involved within the community with social clubs, churches and schools. On or soon after admission, a social history is taken and information from this used to develop a diversional therapy plan which is then reviewed six monthly as part of the care plan review/evaluation. A record is kept of individual resident’s activities and monthly progress notes completed. The resident/family/EPOA as appropriate is involved in the development of the activity plan. There is a wide range of activities offered that reflect the resident needs. Participation in all activities is voluntary.  Dixon House has its own van for transportation. Residents interviewed described weekly van outings, music entertainment and attendance at a variety of community events. The activities coordinator has a current first aid certificate. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Moderate | The resident files reviewed evidenced six monthly care plan reviews completed and were updated at this time. Clinical reviews were documented in the multi-disciplinary review records. Changes to care were not always documented as needs changed. Documentation of GP visits were evidence that reviews were occurring at least three monthly. Short-term care plans were in use for short-term issues. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | The service facilitates access to medical and non-medical services. The registered nurse interviewed confirms that residents, family and the resident’s GP are informed of any referrals made directly to other nursing services or the needs assessment team. Referrals to medical specialists are made by the GP in consultation with the registered nurse. Relatives and residents interviewed stated they are informed of referrals required to other services and are provided with options and choice of service provider where applicable. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | There are policies and procedures in place for waste management. Residents, staff and visitors are protected from harm through safe practice. There is an approved system in place for the safe disposal of sharps. Chemicals are labelled with manufacturer labels. There are designated areas for storage of chemicals and chemicals are stored securely. Laundry and sluice rooms are locked when not in use. Product use information is available. Protective equipment including gloves, aprons, and goggles are available for use by staff. Staff interviewed were familiar with accepted waste management principles and practices. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | PA Low | The facility has a current building warrant of fitness displayed. Assessment for hot water temperature checks are conducted monthly, these are documented to be over 45 degrees at times. All electrical and mechanical equipment has been calibrated and tested and tagged.  The interior is well maintained with a home-like décor and furnishings. The facility has a first floor area that can be accessed via a lift or either of two flights of stairs. Upstairs there are five resident rooms, a tea making area and offices. On the ground floor, there is a large communal lounge and dining area, a chapel and small sitting areas. There are sufficient communal toilets adjacent to the lounge and dining areas. There are small seating nooks available for residents and visitors. Residents were observed to safely mobilise throughout the facility. There is an external designated smoking area. There is easy access to the outdoors. The exterior is well maintained with safe paving, outdoor shaded seating, lawn and gardens. Interviews with three caregivers confirmed there was adequate equipment to carry out the cares according to the resident needs as identified in the care plans. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | There are five single rooms upstairs and 32 downstairs in Dixon House which all have either a full ensuite or individual toilet and basin. There are also communal showers and toilets throughout the facility. The number of visitor and resident communal toilets provided is adequate. Facilities were viewed to be kept in a clean and hygienic state. Regular audits are completed and included in the quality programme. Residents interviewed state their privacy and dignity is maintained while attending to their personal cares and hygiene.  Hand washing and drying facilities are adjacent to the toilet. Liquid soap and paper towels are available in all toilets. Fixtures, fittings and floor and wall surfaces are made of accepted materials to support good hygiene and infection control practices for this environment. The communal toilets and showers are well signed and identifiable and include large vacant/in-use signs. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | The rooms are spacious enough to meet the assessed resident needs. Residents are able to manoeuvre mobility aids around the bed and personal space. All beds are of an appropriate height for the residents. Caregivers interviewed report that rooms have sufficient space to allow cares to take place. The bedrooms are personalised. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | There is a large lounge and dining room and small seating areas. The dining room is spacious, located directly off the kitchen/servery area. All areas are easily accessible for the residents. The furnishings and seating are appropriate for the consumer group. Residents were seen to be moving freely both with and without assistance throughout the audit. Residents interviewed report they can move around the facility and staff assist them if required. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | Dixon House has documented systems for monitoring the effectiveness and compliance with the service policies and procedures. There is a separate laundry area where all linen and personal clothing is laundered by the care staff. Staff attend infection control education and there is appropriate protective clothing available. Care staff complete cleaning/laundry tasks. Manufacturer’s data safety charts are available. Residents and family interviewed report satisfaction with the laundry service and cleanliness of the room/facility. Laundry and cleaning audits are completed as part of the annual audit plan. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | Emergency systems are checked monthly including call bells, emergency lighting and fire alarms. The service has implemented policies and procedures for civil defence and other emergencies. The service has an emergency civil defence box including torches and radios. Emergency lighting and a gas BBQ are available in the event of a power failure. A battery backup supplies power to the emergency lighting. Staff stated that there were plenty of spare blankets available also. The service has extra food and water supplies available for use in the event of an emergency. Call bells were evident in resident’s rooms’, lounge, and toilets/bathrooms. Call bells were observed to be answered appropriately on day of audit. All staff have a current first aid certificate. There is an evacuation scheme approved by the New Zealand Fire Service. Six monthly fire drills are conducted. Security procedures are established. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | All communal and resident bedrooms have external windows with plenty of natural sunlight. General living areas and resident rooms are appropriately heated and ventilated. Residents and family members interviewed stated the environment is warm and comfortable. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | The infection control programme and its content and detail is appropriate for the size, complexity and degree of risk associated with the service. Staff are well informed about infection control practises and reporting. An enrolled nurse is the infection control coordinator and is responsible for infection control across the facility. The management team and external consultant are responsible for the development of the infection control programme and its review. The infection control programme is well established. The infection control committee is part of the two monthly quality meeting. There is external input as required from general practitioners and Medlab. Annual review of the infection control programme has been completed. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | Infection control is managed by the infection control coordinator (enrolled nurse). The infection control coordinator has maintained current knowledge of infection prevention and control. The infection control coordinator has access to infection control personnel within the district health board, laboratory services and the GP. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes the infection control programme, responsibilities and oversight, training and education of staff. The policies have been reviewed. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The infection control coordinator is responsible for coordinating/providing education and training to staff. Infection control education has been provided in the past year. Staff receive education on orientation and as part of the annual education programme.  Resident education occurs at resident meetings such as use of sanitisers and hand washing. Hand hygiene posters have been placed in all resident toilet areas. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Infection surveillance and monitoring is an integral part of the infection control programme and is described in the infection prevention and control policy. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed which includes signs and symptoms of infection, treatment, follow-up, review and resolution. Surveillance of all infections is entered onto a monthly facility infection summary and staff are informed. This data is monitored and evaluated monthly and annually. Infection control education has been provided. There have been no outbreaks. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | Restraint minimisation is practiced. The manager oversees the restraint process within the facility. There are policies around restraint, enablers and the management of residents who may exhibit behaviours that challenge. The service currently has no residents using enablers or restraints. Restraint education has been provided and restraint use is audited and discussed at quality meetings. |

# Specific results for criterion where corrective actions are required

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

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

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

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.3.6  Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Low | Quality activities conducted include monthly internal audits, collection of monthly infection rates and monthly incidents and accidents. The service has access to a software programme provided by the external consultant to input data. Resident and relative surveys are conducted annually. Incidents and accident data is collected for falls, skin tears, bruising, behaviours, and wandering. Results of this data have not been analysed. | Incident and accident data collected has not been analysed to identify trends and opportunities for improvement. | Ensure that incident and accident data is analysed and evaluated to identify trends and ways to improve outcomes for residents.  60 days |
| 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. | PA Low | Corrective actions and quality improvement plans have been developed for health and safety matters and any hazards identified. Corrective actions have also been developed and completed for internal audits. Meeting minutes reviewed do not follow a corrective action format and issues identified have not been followed through. | Corrective actions have not been followed through for issues and areas for improvement identified through meeting minutes for quality, staff or resident meetings. | Provide evidence that opportunities for improvement as identified at meetings are followed through and completed.  60 days |
| 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. | PA Moderate | Incident forms were completed for all resident incidents and accidents. Staff interviewed stated that they have support from the registered or enrolled nurse on duty at the time of any incident. | Incident forms reviewed were not fully completed by a registered nurse to identify full analysis of the adverse event or opportunities to minimise further risks. | Ensure that incidents are fully investigated and that forms are fully completed with registered nurse follow up documented.  60 days |
| Criterion 1.2.7.3  The appointment of appropriate service providers to safely meet the needs of consumers. | PA Moderate | Six staff files were reviewed. Reference checks have been completed for newly employed staff members. Staff sign a confidentiality agreement when employed. Copies of annual practicing certificates are maintained on file. One staff member had a current staff appraisal and two staff members were not yet due for an annual appraisal. Medication competencies for registered nurses, enrolled nurses and senior caregivers were current. Copies of qualifications were on file and senior staff have current first aid certificates. | (i) Six of six staff files reviewed did not evidence a copy of an employment contract; (ii) five of six staff files did not have a signed job description; (iii) four of six files did not have completed orientation documentation; and (iv) three of six staff did not have a current annual appraisal completed. | (i) Ensure all staff have a signed employment contract in place or evidence of a collective agreement contract; (ii) ensure all staff files have a signed job description; (iii) ensure all new staff complete orientation documentation; and (iv) ensure that annual appraisals are completed for all employees.  60 days |
| 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. | PA Low | The medication management system includes a medication policy and procedures that follows recognised standards and guidelines for safe medicine management. All residents have individual medication orders with photo identification and allergy status documented. Out of date medication has not all been discarded. | The medication fridge had out of date suppositories stored, out of date yogurt and one opened eye drops not dated. | Ensure that all medication is within date and eye drops are dated on opening.  30 days |
| Criterion 1.3.5.2  Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Moderate | The service has a comprehensive care plan template that includes headings for all aspects of resident care. All resident files reviewed had a long-term care plan, however these were not always fully completed and did not all reflect resident needs as identified by the InterRAI assessment. | I) Three of seven long-term care plans reviewed had areas of the template not completed.  ii) Three of seven did not fully reflect the InterRAI assessment.  iii) Two of two dementia care plans did not include interventions to manage documented behaviour.  iv) One resident with falls linked to postural hypotension did not include strategies to minimise the risk of further falls in the care plan. | i) Ensure care plans are fully completed.  ii) Ensure that care plans reflect the InterRAI assessment.  iii and iv) Ensure care plan interventions are documented for areas of risk.  60 days |
| Criterion 1.3.6.1  The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA High | Four residents with dementia diagnoses are receiving DHB top-up funding for extra care and service during the afternoon/evening period. An extra caregiver is employed to provide activities and diversional therapies during the hours of 3pm – 8pm. Two of four residents receiving care under the dementia top up funding contract were reviewed. One resident has six incident reports for wandering away from the facility in the past four weeks. One resident has challenging behaviours including aggression towards staff, pinching, kicking and resistant to cares. Care plan interventions reviewed were not comprehensively completed to include behaviour management and monitoring strategies. Input has been sought from the mental health services for older people and/or dementia outreach support nurse. Although staff report that visits have occurred, there is no documented evidence in the resident files. Staff report that minimal assistance and guidance has been provided. The facility is situated adjacent to a busy main road, and other hazards exist including a nearby stream. On the day of audit, the nurse manager contacted the GP for an urgent review of the resident and contacted the mental health services for the older person for urgent review and transfer. The DHB funding and planning manager was also contacted by the auditors to review the situation and assist with more appropriate placement for the wandering resident. A placement has been found for the resident and the support services are working through the process of placing the resident in a dementia specific facility.  Wound care documentation was completed appropriately for nine of thirteen resident’s wounds. Incident reports reviewed for August and September 2016 did not include a completed set of neurological observations where the resident had sustained a head injury. | (i) One resident with a diagnosis of dementia wanders away from the facility as evidenced by recent incident reports of six incidents in four weeks.  (ii) Care plan interventions are lacking and do not describe the care and support required to manage and monitor one resident with wandering behaviour and physical aggression and one resident with physical aggression.  (iii) There is no documented frequent monitoring of the resident’s whereabouts.  (iv) Specialist support from allied health is not documented as occurring and staff report a lack of guidance and assistance.  (v) Where caregivers have documented issues in progress notes, there is no documented registered nurse follow-up or review for one resident with disinhibited behaviours, and one resident with a urinary tract infection.  (vi) Incomplete wound documentation included more than one wound on a form for three wounds; the size and grade of the pressure injury was not documented; one wound did not have a wound care plan.  (vii)Neurological observations were not completed for two residents who had sustained a head injury. | (i) Ensure that all residents are appropriately place to manage safety and risk.  (ii) Ensure that care plans include all documented interventions and monitoring requirements for residents at risk.  (iii) Ensure that monitoring of high risk residents occurs.  (iv) Ensure that specialist support and advice is documented as occurring.  (v) Ensure that registered nurses follow up on identified issues.  (vi) Ensure that all wound documentation is completed appropriately for individual wounds.  (vii)Provide evidence that neurological observations are completed for residents with obvious and suspected head injuries.  7 days |
| Criterion 1.3.8.3  Where progress is different from expected, the service responds by initiating changes to the service delivery plan. | PA Moderate | The RNs are expected to review, evaluate and update care plans six monthly. InterRAI assessments and paper based assessments are included as part of six monthly reviews of care (link also to 1.3.5.2 for InterRAI and linkages to care plans). Where needs change between the six monthly reviews of care, the care plans were not always updated. | i) Two residents who have recently commenced on the palliative care journey did not have their care plans updated to reflect the change in care needs; and ii) one resident whose husband had recently died did not have this reflected onto their care plan. | Ensure care plans are updated as resident needs change.  60 days |
| Criterion 1.4.2.1  All buildings, plant, and equipment comply with legislation. | PA Low | Assessment for hot water temperatures checks are conducted monthly, these are documented to be over 45 degrees at times. All electrical and mechanical equipment has been calibrated and tested and tagged. | In Rata wing, monthly hot temperatures are documented to have been 47 to 48 degrees Celsius since January 2016. In Aroha wing, hot water temperatures were documented to have been at 49 degrees from January to June 2016. Hot water temperatures were in the process of being addressed on the day of audit. | Ensure hot water temperatures in resident areas do not exceed 45 degrees Celsius.  60 days |

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

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

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

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

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End of the report.