

Dixon House Trust Board - Dixon House Rest Home

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity: Dixon House Trust Board (Inc)

Premises audited: Dixon House Rest Home

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 1 November 2017 End date: 2 November 2017

Proposed changes to current services (if any): The Dixon Trust Board is wanting to have all 37 of its current beds as dual purpose for the delivery of rest home or hospital level care.

Total beds occupied across all premises included in the audit on the first day of the audit: 35

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

Indicator	Description	Definition
	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 an aged care facility on the west coast of the South Island, which currently provides rest home level care for up to 37 residents and is intending to deliver hospital level care making all beds dual purpose. Hence, a partial provisional audit was undertaken alongside a routine unannounced surveillance audit against the Health and Disability Services Standard and the service provider's contract with the district health board. The partial provisional audit found 20 of the 37 beds would be suitable for hospital level care residents.

The service is operated by the Dixon House Trust Board and is managed by a facility manager who commenced her role at Dixon House approximately three months prior to this audit. Dixon House is collectively owned by four local Greymouth church denominations. Residents and families spoke positively about the care provided at this facility and of the local reputation it has.

The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family, management, staff and a general practitioner.

Of the nine previously raised corrective actions, seven have been fully addressed. One in relation to the analysis of data for quality improvement purposes remains open, although the issue that was raised earlier has been addressed and new aspects identified. Another corrective action regarding shortcomings in staff records remains open for similar reasons to those previously raised. A new corrective action has been raised regarding the need for a detailed and time-framed transition plan for the prospective delivery of hospital level care and another for the absence of documentation relating to fire evacuation planning and the latest trial evacuation.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Interviews, observations and documentation reviewed confirmed there is effective open communication between staff, residents and families. Although not known to have been required, the facility has access to formal interpreting services through the local District Health Board.

The facility manager is responsible for the management of complaints. A complaints register is maintained and demonstrated that complaints have been resolved promptly and effectively.

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.
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The Dixon House Trust Board is the governing body and is responsible for the service provided at this facility. A business and quality and risk management plans are documented and includes the scope, goals, values and mission statement of the

organisation. Systems are in place for monitoring the services provided, including monthly reporting by the facility manager to the governing body.

The facility is managed by an experienced and suitably qualified manager who is a registered nurse. A quality and risk management system is in place which includes an annual calendar of internal audit activity, monitoring of complaints and incidents, health and safety, infection control, restraint minimisation and resident and family satisfaction. Collection, collation and analysis of quality improvement data is occurring and is reported to the quality and staff meetings, with discussion of trends and follow up where necessary. Meeting minutes, graphs of clinical indicators and benchmarking results are displayed. Adverse events are documented on accident/incident forms and seen as an opportunity for improvement. Corrective action plans are being developed, implemented, monitored and signed off. Formal and informal feedback from residents and families is used to improve services. Actual and potential risks are identified and mitigated and the hazard register is up to date.

A suite of policies and procedures supplied by an external contractor cover the necessary areas, are current and reviewed regularly.

The human resources management policy, based on current good practice, guides the system for recruitment and appointment of staff. A comprehensive orientation and staff training programme ensures staff are competent to undertake their role. A systematic approach to identify, plan facilitate and record ongoing training supports safe service delivery, and includes regular individual performance review.

The rosters demonstrate that staffing levels and the skill mixes meet contractual requirements and the changing needs of residents. The manager undertakes most out of hour's calls, although a relief registered nurse is available in her absence.

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.		Standards applicable to this service fully attained.
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Registered nurses oversee the admission of new residents, the interRAI assessments, development of care plans and their ongoing review. They are supported by enrolled nurses, while trained caregivers undertake most of the day to day care and support. A medical review is undertaken on admission, when needed and at least three monthly. Residents have access to input from allied health professionals when necessary. On call arrangements for support from senior staff are in place. Shift handovers and progress notes enable continuity of care.

Care plans are individualised, based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage new problems that arise. All residents' files reviewed demonstrated that that needs, goals and outcomes had been identified and were being reviewed on a regular basis. Residents and families interviewed reported being well informed. They confirmed they are involved in care planning, and evaluation of the care and support provided, at the level they choose.

The planned activity programme, overseen by a diversional therapist, provides residents with a variety of individual and group activities and maintains their links with the community. A facility van is available for outings.

Medicines are managed according to policies and procedures based on current good practice and consistently implemented using a paper based system. Medications are administered by registered nurses and caregivers, all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of the residents with special dietary needs and personal preferences catered for. The kitchen was well organised and clean. Kitchen staff have received training in food safety requirements. Residents verified satisfaction with meals.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Some standards applicable to this service partially attained and of low risk.
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Dixon House is an older facility that was purpose built and had two wings added some years later. Rooms are of adequate size to enable staff to provide personal care; however, the Aroha and Parkview wings are the preferred areas for hospital level care due to them being downstairs and their proximity to the nurses' station.

Implemented policies guide the management of waste and hazardous substances. Protective equipment and clothing is provided and used by staff. Chemicals, soiled linen and equipment are safely stored. All laundry is undertaken onsite, with internal audit systems in place to monitor the effectiveness.

All building and plant complies with legislation and a current building warrant of fitness and a local council inspection certificate were displayed. A preventative and reactive maintenance programme is implemented.

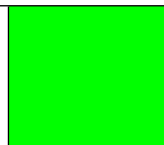
Communal areas are spacious. External areas are safe and enable residents to walk around the mature gardens easily, or sit and enjoy their surrounds.

Emergency procedures are documented and displayed. There is a sprinkler system, an evacuation plan, a dedicated emergency assembly point and a range of fire safety equipment. An emergency generator and emergency supplies are available. Residents reported a timely staff response to call bells. Staff undertake security checks each night.

All personal and communal rooms have windows that can be opened, and electric heating systems are installed. The facility is being maintained at a comfortable temperature.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.

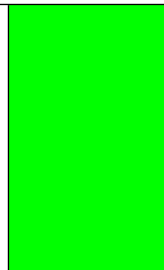


Standards applicable to this service fully attained.

Policies and procedures that support the minimisation of restraint are in place. Staff were familiar with these documents and during interview demonstrated a sound knowledge and understanding of the restraint processes and of de-escalation principles and practices. There were no enablers or restraints in use at the time of audit. Training records showed staff receive training at orientation and thereafter every two years. This includes all required aspects of restraint and enabler use, alternatives to restraint and dealing with difficult behaviours.

Infection prevention and control

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



Standards applicable to this service fully attained.

An infection prevention and control programme is documented within the infection control policy and procedure manual, which has been reviewed for the current year. The programme is being implemented by a suitably qualified infection control nurse with input from other staff, including the facility manager. There is access to external specialists should this be required.

Infection surveillance is undertaken with the analysis of infection related data consistently occurring. Reports are presented to the quality meeting and to wider staff groups with applicable recommendations being made for quality improvement purposes. The data

is benchmarked nationally against other aged care services. Follow-up actions, such as education on handwashing is taken when indicated.

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	21	0	4	1	0	0
Criteria	0	55	0	4	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>A policy and procedure on compliments and complaints was available. The documentation and associated forms meet the requirements of Right 10 of the Code of Health and Disability Services Consumers' Rights (the Code). Residents and any family members present receive information that includes how to make a complaint when they are admitted. The registered nurse confirmed they also talk about this process. One resident was not aware of how to make a complaint but said she would talk to someone such as a family member if she was not happy. Complaints forms were sighted at the front entrance of the facility.</p> <p>The complaints register was reviewed. This showed that three complaints have been received since the last audit and correspondence on file showed that all had been followed through to resolution within the required timeframes as specified in the Code. Action plans reviewed show any required follow up and improvements have been made, including for two verbally expressed concerns not in the complaints register.</p> <p>Staff confirmed during interview that they understand the complaint process and what actions are required; however, all said they would report any complaint direct to the manager. The manager is responsible for complaints management and follow-up. During interview she noted that whenever possible she likes to deal with things earlier rather than later.</p>
Standard 1.1.9:	FA	During interview, staff were aware of the need to communicate effectively with residents and family members and to

<p>Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>keep them informed. They talked about the principles of open disclosure, which are also described in the organisational policies and procedures. Adverse event forms sighted reflected that next of kin are being informed of any incidents, according to the resident's preferences. Residents and family members stated they are kept well informed about any changes to their/their relative's status, are advised in a timely manner about any incidents or accidents and that outcomes of medical reviews are discussed with them when appropriate. A family communication recording form confirmed communication is two way and ongoing. There was evidence of resident/family input into the care planning process, which may be undertaken by telephone or email when family members are absent. Records of those involved were noted on care plans.</p> <p>Interpreter services are able to be accessed via the local District Health Board interpreter services when required. However, the manager noted that such services are limited on the West Coast and creative techniques would be required. It was reported that family members have been used and that other non-verbal prompts could be used if required.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>PA Low</p>	<p>Dixon House is a 37 bed rest home in Greymouth. On the day of audit 35 residents were in residence. The facility is governed by the Dixon House Trust Board, which was formed in 1970. The Board is comprised of two elected members from the Roman Catholic, Presbyterian, Methodist and Anglican churches of Greymouth, who own Dixon House. They sit alongside four other elected community representatives. A team of others including the facility manager, the quality consultant (who is also a trust board member), a finance manager/secretary, solicitors, accountants and financial auditors support the Board.</p> <p>A strategic plan, which is reviewed at the annual general meeting in October of each year, outlines the purpose, values, scope, direction and goals of the organisation, as does the quality and risk management plan. The documents describe annual and longer term objectives and the associated operational plans. The facility manager attends the monthly Trust Board meetings and provides reports against a list of predetermined topics that are intended to monitor occupancy, financial performance, quality management, emerging risks and issues of concern.</p> <p>The service is managed by a suitably qualified and experienced facility manager who is a registered nurse. She has had previous clinical experience and charge positions in intensive care units, medical wards and assessment, treatment and rehabilitation units. In addition to appraisal and management education sessions, she has undertaken a post graduate university level leadership and management course. The training record from her previous district health board role was reviewed and showed extensive professional development opportunities had been undertaken at an advanced learning level in both clinical and management areas. Responsibilities and accountabilities for the facility manager are defined in a position description and an individual employment agreement. The facility manager confirmed her knowledge of the sector, regulatory and reporting requirements. She is supported by a clinical manager, other registered and enrolled nurses with long standing employment at Dixon House, the Trust Board members and a contracted quality consultant.</p> <p>The service holds contracts with the District Health Board to provide rest home level care for residents aged 65 and</p>

		<p>over. In addition, the service is funded to provide care and support for up to six people who have been assessed as requiring dementia care. Dixon House's Trust Board is seeking to be able to provide hospital level care for up to 20 residents and this surveillance audit includes the partial provisional requirements to assess the ability of the service provider to deliver such services.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>The facility manager informed that in her nearly three months of employment, she has not yet had any absence from her role. Plans in place include that in her absence, the clinical manager will undertake specific duties under delegated authority. Certain trust board members, including the board chair, are available on call as necessary. The previous temporary manager is still available for advice and support should this be required. Staff reported that despite all the changes over recent months they have always been able to continue with the care of the residents and feel supported by whomever has been in charge.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	PA Low	<p>The organisation has a documented quality and risk plan, which reflects the principles of continuous improvement and is understood by management and staff. This includes the management of incidents and complaints, internal audit activities, resident and family member surveys and monitoring of clinical outcomes including infections and any use of restraint.</p> <p>Policies and procedures reviewed for the surveillance cover the necessary aspects of the service and contractual requirements. The documents have been provided by a quality consultant and were reviewed earlier in 2017 to ensure they also reflect the delivery of hospital level care. Documents are controlled using a system that is monitored by the quality consultant. It enables a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>Two monthly quality meetings, staff meetings, a dementia staff meeting and three monthly residents' meetings were all minuted. Meeting minutes included reports on the analysis of adverse event data and of infection related data, which addressed a previous corrective action. However, the same criteria continues to be partially attained as reports on other aspects of the quality system, such as surveys and internal audits, included numeric data only and there was a lack of evidence of related analysis and discussion for quality improvement opportunities. This was especially evident for the components of the well documented health and safety system. The meeting minutes also included brief comments related to discussions on clinical problems and/or outcomes. Staff reported they are</p>

		<p>required to read meeting minutes if they have not attended the meeting and are asked to read at least one new policy a week to ensure they keep updated.</p> <p>Internal audits and resident and family surveys have been completed. The recently employed facility manager has chosen to do a full round of internal audits herself. A detailed corrective action log has been developed following a series of internal audits and a review of parts of the quality system such as adverse event reporting, the residents' survey and staff training. Each item on the log identifies the source of the problem, has an action plan and is time-framed. The manager has not yet been in the role long enough for them all to be closed out, although in conversation noted that all corrective actions were going to improve quality of functioning in one or more areas. The previous corrective action relating to opportunities for improvement not being identified has been addressed.</p> <p>The facility manager described the processes for the identification, monitoring and reporting of risks and development of mitigation strategies. An organisational risk register shows consistent review and the updating of risks, risk plans and the addition of new risks.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Accident/incident forms are being completed following incidents and adverse events. A sample of incident forms that were reviewed showed these are being fully completed, incidents are investigated, action plans developed when relevant and actions are followed-up in a timely manner. These forms demonstrated that appropriate corrective actions have been taken to address the corrective action raised at the last audit when it was found that incidents were not being fully investigated. Adverse event data is collated, analysed and reported to the two monthly quality meetings and the staff meetings. Meeting minutes show discussion in relation to trends and frequency of events is occurring with quality improvements being identified and followed through.</p> <p>Essential notification reporting requirements are being met with routine reports and updates being provided to the relevant authority such as the District Health Board. The facility manager provided information that demonstrated her awareness of other reporting requirements, such as for significant injury incidents, infections, an unexpected death or any change in circumstances. During interview, the facility manager also advised that there has not been any significant event that required reporting to the Ministry of Health since the previous audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are</p>	<p>PA Moderate</p>	<p>A suite of human resources policies and procedures guide recruitment, appraisal and employment processes and are consistent with good employment practice and relevant legislation. Recruitment processes include referee checks, interviews, police vetting and validation of qualifications and practising certificates (APCs), where required. The manager described her familiarity with good employment practices and staff interviews confirmed they had been interviewed on entry, have annual appraisals and have access to a range of training opportunities. All staff files reviewed have a signed current position description which defines the key tasks and accountabilities for their</p>

<p>conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>various roles. This addresses part of a corrective action raised at the last audit, as does the fact that all staff files reviewed had a current annual performance appraisal. Performance reviews after a three-month period are being completed and copies were in the files of more recently employed staff.</p> <p>Copies of annual practising certificates for registered and enrolled nurses were on file and those for the facility GPs had been accessed on line. There is enough trained and competent registered nurses who are maintaining their annual competency requirements to be able to undertake interRAI assessments.</p> <p>Staff talked about the orientation process that they undertake. The manager informed that she had placed a blank orientation checklist in each person's file and was progressively checking each staff person's knowledge, training and competencies to ensure requirements are met. To date 10 of the 40 staff have reportedly been checked using this system; however, of the six staff files checked three did not demonstrate an orientation programme had been undertaken. The part of the previously raised corrective action regarding a lack of staff orientation records remains open, as does the need for staff to have a signed employment agreement. Staff files still do not have current employment contracts as the Dixon House Trust board has yet to finalise the new employment agreements that will reflect the pay equity process.</p> <p>Systems are in place to plan, facilitate and record ongoing training requirements of staff. A number of caregivers have either completed a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB, or are in line for the next planned intake. Mandatory training requirements are defined and staff training schedules for 2017 and 2018 were sighted. Attendance records for the weekly training sessions show that an average of seven to eight staff attend most sessions, therefore many are not meeting the mandatory training requirements. Staff files have scant training records in them.</p> <p>The need for certainty that staff training requirements are being met has been raised in the corrective action related to other human resources shortcomings, including the need for a transition plan to identify the specific staffing requirements for the service provider to be able to provide hospital level care.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>PA Low</p>	<p>A staff skill mix policy and procedure and one on annual leave and rostering guide the staff allocation process. Rosters are completed by the administrator and checked by the facility manager. The roster is a set one with all staff doing the same shifts on the same days each week unless they do a relief duty. The clinical manager works Monday to Thursday 7am to 3.45pm. There are two other registered nurses who work casual hours when needed. Two enrolled nurses share duties Monday to Sunday 9am to 3pm. One caregiver works 7am – 11.30am; two work 7am – 3.30pm and an additional dedicated 'runner' is rostered when occupancy and/or acuity is higher. All staff have dedicated wings and the person upstairs in Rata will assist downstairs where needed. Afternoon shifts are covered by caregivers 3.30pm - 11pm; two cover 2pm – 7.30pm, a dementia carer works 3pm - 8.30pm and a runner covers 5pm – 8.30pm. An enrolled nurse covers 3.30pm - 11pm daily, except on Sundays when a registered nurse undertakes this duty. Night shifts have an enrolled nurse and a caregiver 11pm – 7.15am. Auxiliary staff include cooks, kitchen assistants, cleaners (Monday to Friday), gardener, maintenance person, a qualified diversional</p>

		<p>therapist on four days a week and a mobility person for four hours on three days a week.</p> <p>The facility manager, who is also a registered nurse, is on call over 24 hours Monday to Friday morning. One of the registered nurses covers Friday morning to Monday morning. Registered and enrolled nurses have cardiopulmonary resuscitation competency certificates and/or first aid certificates. Senior caregivers, the diversional therapist and the van driver have first aid certificates, copies of which were sighted.</p> <p>Staff confirmed during interview that there is adequate staffing on each shift and that they only need to ask and an additional person will be rostered while they are extra busy, or a runner will be allocated to cover busy timeframes. Staff who have completed dementia training are rostered on to the wing with the person with dementia and this is evident on the roster. Likewise the most senior person, who is responsible for medicines for that shift, is identifiable on the roster.</p> <p>As noted in 1.2.7.3 above, details of the change process for this service to provide hospital level care have yet to be finalised. A corrective action has been raised in relation to the need for staffing levels for hospital level care to be clear and for evidence that there is registered nurse cover for 24 hours a day on seven days a week. This corrective action is rated low risk as details are required prior to occupancy.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication management policy and procedures are current. They are consistent with medicine management related legislation and the Medicines Care Guide for Residential Aged Care. Medicines are stored in a locked cupboard or medicine trolley in the nurses' station, which is kept locked when unoccupied.</p> <p>Due to unforeseen circumstances, it was not possible to observe a medicine administration round; however, the processes undertaken for the administration of three medicines outside of the meal time were observed. Safe processes were observed. Explanations of medicine administration process by one staff person demonstrated a good level of knowledge and an understanding of their role and responsibilities around medicine management. Records sighted confirmed that all staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked against the prescription by a registered nurse and one other person who signs them off when accurate. There was no evidence of the concern raised for corrective action at the last audit, as all medications sighted were within current use by dates.</p> <p>Controlled drugs are stored securely in accordance with requirements and are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge in the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and</p>

		<p>discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three monthly GP review is consistently recorded on the medicine chart. There was evidence of this occurring more frequently in two records sighted.</p> <p>At the time of audit, there were three residents who self-administered one or more of their medicines. Appropriate processes were in place to ensure this is managed in a safe manner.</p> <p>Medication errors are recorded on an accident/incident form and reviewed by a registered nurse. There is a process for comprehensive analysis of any medication errors, and compliance with this process is verified.</p> <p>Standing orders are signed by GPs; however, the registered nurse informed that these are not really used now. Verbal orders are being signed within 48 hours and an example of this being followed through was observed during the audit.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. Nutritional assessments are reviewed every six months and as needed. The registered nurses are responsible for informing the kitchen staff of personal food preferences, special diets and modified texture requirements. All such needs are documented and accommodated in the daily meal plan. Records of these were viewed in the kitchen and the process for implementation explained by the cook. There are not currently any residents for whom special equipment is required to meet their nutritional needs.</p> <p>Food is prepared on site by two cooks who work different days. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented.</p> <p>Resident satisfaction with meals was verified through resident, family and visitor interviews, a satisfaction survey and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal and those requiring assistance had this provided.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded. The food services manager has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training under infection prevention education.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are</p>	FA	<p>At the certification audit there were examples of service delivery plans not describing the support required for some of the residents. The registered and enrolled nurses informed during interview that additional hours have been granted for care plan reviews and the systems had been changed to ensure such shortfalls were no longer occurring. The care plans of the tracer and the extended sample were complete. The identified problems in the care</p>

consumer focused, integrated, and promote continuity of service delivery.		plans reflected the interRAI assessment outcomes and the identified nursing diagnoses all had applicable interventions described. There was no evidence of the issues identified in the finding raised at the last audit.
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Observations made during the audit, alongside documentation reviewed and information from staff, resident, family and visitor interviews confirmed that the care being provided to residents is consistent with their assessed needs, personal goals and the interventions within the care plans. The care and support being provided was seen to be individualised. Registered nurses described how they utilise the outcomes from interRAI and stated that short term care plans are developed for short term problems. These were evident. In the service delivery plans, as noted in 1.3.3, the GP verified that medical input is sought in a timely manner, medical orders are followed, and care is of a high calibre. Caregivers confirmed during interview that care is provided as outlined in the documentation and according to the information provided at handovers and by registered and enrolled nurses. Equipment and resources available were suited to the identified needs of the current residents and to rest home level care.</p> <p>A corrective action raised at the last audit noted a number of examples in which residents were not receiving the level of care they were assessed as requiring or in which documentation did not demonstrate appropriate follow-up had occurred. There were no such shortcomings identified during this surveillance audit.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>A qualified diversional therapist is responsible for the activity programme. This person was not able to be interviewed as she was absent on the two days of audit. Monthly programmes are developed and examples of these were sighted. The programmes are varied and include a diverse range of activities and reflect the assessed needs of current residents. There was good evidence of community integration and of individualised activities for those less comfortable in group environments. Caregivers were involved in occupying the residents during the audit and the new facility manager informed that she is asking them to be more involved and not just to leave it to the activities person. Residents enthusiastically described some of the activities programme with one person noting the one to one attention she receives and appreciates.</p> <p>Comprehensive profiles of the resident were found in each of the files reviewed. Activity plans and their reviews were of a very high calibre with all interventions detailed, attendance records maintained and reviews and evaluations linking directly to the personal goals of the residents.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are</p>	FA	<p>The service delivery plans of the tracer and four other resident that were reviewed demonstrated that interRAI reassessments are being completed every six months, as are those specifically for continence, pain, nutrition, falls and skin integrity. Results of these are being considered alongside review of the documented care plans. Where necessary adjustments are being made to the care plan both at the formal six monthly evaluations and when a</p>

<p>evaluated in a comprehensive and timely manner.</p>		<p>resident's condition changes.</p> <p>Examples of short term care plans for issues such as skin tears, shortness of breath and urinary infection were in three of the five files reviewed. All had been consistently reviewed. Progress had been evaluated as clinically indicated with most having daily reviews. A wound management plan included evaluation with each dressing change.</p> <p>Residents confirmed they are involved in reviews in that staff ask if they are satisfied with the care and support they receive and whether they want anything done differently, or any additional cares provided. One family member stated how much the staff follow up on any concern or questions she may have.</p> <p>Progress notes are written for each shift and registered and enrolled nurses follow-up on any comment the caregivers may have. Caregivers said the follow-up from senior staff is important to them and noted that the current facility manager has led some changes in these processes.</p> <p>As residents' care plans are being adjusted when their condition(s) changes; there was no evidence to suggest the finding raised at the last audit is still an issue of concern.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>The management of waste disposal is occurring according to documented policies and procedures. There are not currently any recycling systems available, although investigations on how this might work are underway. All types of rubbish is disposed into a skip and a private contractor removes this three times a week. Data sheets are available for the use and storage of hazardous substances including cleaning and laundry products and these are being followed through. Key pad locks are installed on the doors of all cupboards and rooms where potentially hazardous products are stored. An external agent provides sharps containers and removes them from the facility when the container is full.</p> <p>Staff have access to a range of personal protective equipment, including plastic and rubber gloves, goggles, plastic aprons and masks for use when required. Observations of personal protective equipment being used appropriately were made during the audit.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an</p>	<p>FA</p>	<p>There is a current building warrant of fitness that expires 27 February 2018 on public display. A local council annual fitness inspection dated 13 June 2017 was also on display. Although no alterations have been made to the building since the last audit, the need for this surveillance to cover partial provisional requirements meant all sections of Outcome 1.4. Safe and Appropriate Environment, were reviewed.</p>

<p>appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		<p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose. Observations of the environment showed that despite the facility being older, it is being well maintained. A proactive and reactive maintenance programme of buildings, plant and equipment is in place and tasks are signed off when completed. Records for the testing and tagging of equipment and calibration of bio medical equipment are dated September and October 2017, except for the hoist which is next due January 2018, the annual lift inspection July 2017 and last fire equipment checks August 2017. The maintenance person recently resigned and was therefore not available for interview. A corrective action that was raised at the last audit in relation to hot water temperatures has been closed as records sighted showed that hot water temperatures have been consistently recorded on a monthly basis and all were below 45 degrees Celsius in areas where residents have access.</p> <p>A gardener is contracted at 15 hours a week to maintain the grounds. External areas were observed to be being safely maintained and are appropriate to the resident groups and setting. Ramps and level entry is evident from all exits. Residents may walk around parts of the garden, or sit in the more open areas. Efforts are made to ensure the environment is hazard free and that residents are safe. Residents are happy with both the internal and external environments and all interviewed noted the 'homely' nature of this facility.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>There is a mix of configurations of toilet and shower facilities within the facility. Ten rooms and five apartments within the rest home have a full ensuite of a shower, basin and toilet while 11 rooms have just a toilet off their rooms and use one of the two shared shower facilities. One of the shared bathrooms has a bath in it. There are two additional shared toilet facilities. Ensuities, toilets and shared bathroom facilities are of varying sizes with 21 of the total number being wheelchair accessible. All residents' rooms except one have at least a vanity for handwashing in either the room or ensuite.</p> <p>Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories such as shower chairs are available to promote residents' independence. There is sufficient toilet, showering and bathing equipment for the service to commence providing hospital level care. The facility manager has created a list of additional equipment that will be required as hospital level care numbers increase. There is a downstairs sluice room.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are</p>	<p>FA</p>	<p>Residents' rooms are of varying sizes with even the smallest being of sufficient size to manoeuvre equipment such as hoists and mobility equipment. The apartment rooms are larger again with several having the bedroom separate from the sitting area and capable of having a queen bed with space around. One room was built to accommodate two people; however, all current residents have their own room and all rooms are personalised according to</p>

<p>provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>		<p>individual preference.</p> <p>Staff confirmed the downstairs rooms are easy to move within and some who have previously worked in hospital care confirmed they believed that they are large enough for hospital level care residents. Residents interviewed were all happy with their room, enjoying the view from it, its large size, or how light it is.</p> <p>There are five good sized residents' rooms upstairs; however this area is some distance from the nurses' station and the lift up to them is small. This area is not suitable for hospital level care residents.</p> <p>It was noted that the 12 rooms in the downstairs Dixie Wing, are further from the nurses' station and less suitable for hospital level care. The more recently constructed Aroha and Parkview wings both have 10 rooms, have wider corridors and are both in close proximity to the nurses' station. These would be suitable for hospital level care with or without ensembles, as the shared showers and toilets are also of suitable size.</p> <p>Mobility scooters are stored in a designated area and do not impede walkways or create a hazard for mobile residents.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>Dining and lounge areas are spacious and enable easy access for residents and staff to mobilise around and to use mobility equipment within. Strategically positioned smaller sitting areas throughout the facility have easy chairs in them and enable people to meet in small groups, enjoy the view, or meet more privately. On the second day of audit the large lounge area, which was usually open plan with the dining area, had been sectioned off for residents to enjoy music playing. Furniture is appropriate to the setting and resident needs. Residents in a front sunroom talked about this being a favourite area for some people and were observed to be enjoying the pleasant outdoor environment and the general activity at the entrance.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services</p>	<p>FA</p>	<p>One of the staff responsible for cleaning duty was interviewed and confirmed she has received trained in managing chemicals and is confident about what is expected of her. Records of staff training on chemical use and storage were sighted in staff files. Cleaning chemicals are stored in a locked cupboard opened via a numeric key pad. Chemical data sheets were available, as were laundry and cleaning schedules and related policies and procedures. The laundry has been built to ensure a clear dirty to clean flow of laundry processes occur.</p> <p>Cleaning and laundry processes are monitored for effectiveness as part of the internal audit system. The manager has undertaken internal audits on cleaning and laundry using a tool that has been developed for the purpose.</p>

<p>appropriate to the setting in which the service is being provided.</p>		<p>Records of these were sighted and the manager pointed out laundry and cleaning related corrective actions in the corrective action log, which are expected to further improve the effectiveness and consistency of related good practices. These actions are being followed up via the quality management system and are reported in quality and staff meeting minutes.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>PA Low</p>	<p>Policies and procedures on emergency management are in place as is a comprehensive disaster management plan. The facility manager is currently redoing flip charts to enable faster access to such information. Staff training records confirmed that service providers are receiving appropriate training and information about how to respond to emergency situations. The facility has smoke alarms, a sprinkler system, emergency lighting and smoke stop doors, all of which are being regularly checked by a contracted compliance company. Trial fire evacuations have been completed however the records available were not current and the fire service letter approval of the fire evacuation was also not available. Evidence of these has been requested in a corrective action.</p> <p>A civil defence kit, an emergency water tank, extra food supplies and a diesel generator are available for use in the event of an emergency. These are being checked and signed off every six months and the generator started monthly.</p> <p>The call bell system were checked and were operating. Alarm buttons are in all bedrooms, communal areas and bathrooms. Although only a few responded, a resident survey confirmed they are answered promptly, which was reiterated by residents during interview.</p> <p>Doors and windows are locked at nightfall and late visitors need to ring the bell for entry. Staff undertake security checks during evening and night shifts. There have not been any security scares reported; although it was observed that they do not have security latches. Following discussion with the facility manager, she is considering having these installed to further ensure residents' security despite most windows being difficult to enter from the outside because of mature planting and the building configuration.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment</p>	<p>FA</p>	<p>All residents' rooms and communal areas have external windows that are able to be opened. Various types of electric heating are in use throughout the facility with a heat pump in the main lounge and dining area, oil column heaters in residents' rooms except in the two wings where underfloor heating has been installed and convection heating in the hallways. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature including during winter months.</p> <p>A designated smoking area is under shelter but away from open windows and doors.</p>

<p>that is maintained at a safe and comfortable temperature.</p>		
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>Staff education, policy and procedure documentation and the quality and risk management system, which are all components of the infection prevention and control programme, are contributing to minimising the risk of infection to residents, staff and visitors. Infection control management is guided by a comprehensive infection control manual, specific to Dixon House. The infection control programme and manual has been reviewed this year to ensure it meets the requirements for hospital level care.</p> <p>A registered nurse is the designated infection control nurse who coordinates implementation of the programme. The role and responsibilities are defined within the documentation in a job description. Infection control matters, including surveillance results, are tabled at the quality and risk meetings. Staff interviewed confirmed they receive infection control education and that they are required to read infection control policies and procedures. The manager informed that the infection control nurse from the local district health board was due the week after the surveillance for the next education session. Records sighted confirmed this report.</p> <p>Signage at the main entrance to the facility requests anyone who is, or has had specific symptoms in the past 48 hours not to enter the facility. The infection control manual provides guidance for staff about expectations around going to work if they have been unwell. Staff interviewed were aware of actions to take if a resident is suspected of having an infection.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Policy and procedures within the infection control manual described the infection surveillance process. Infection control recording forms are completed when a person is suspected of having an infection, or has been diagnosed with an infection. Records of these are reviewed by the infection control nurse who collates the information, enters it electronically and graphs and analyses the information. Comparisons with data from previous months and years are made, any trends are extracted and any preventive actions are identified. The electronic system enables benchmarking with other aged care facilities throughout the country. Benchmarking has confirmed that infection rates in Dixon House vary on different months from between being equal to and below average for the sector. In the absence of the infection control nurse, the manager and a registered nurse discussed the processes and provided the relevant documentation.</p> <p>Reports on the findings, or any infection related corrective actions are presented to the quality and risk and staff meetings where the figures and corresponding issues are further discussed. Results of the surveillance programme are recorded in the meeting minutes, which staff are provided with a copy of. New infections and any required management plan are discussed at shift handovers, to ensure early intervention occurs. Results of an infection control internal audit resulted in a focus on the promotion of good handwashing practices.</p>

<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Policies and procedures in relation to restraint minimisation and safe practice were viewed and cover the requirements of the standard. The policy and procedure provided to staff to read this week (Refer 1.2.3), is the one on restraint minimisation and safe practice. In addition to descriptions on three different types of restraint, the documents describe the three forms of restraint that have been approved for this facility, which are bed rails, a lap belt around the person and the chair and a lazy boy fall out chair.</p> <p>Staff interviewed were aware of safety issues in relation to enabler and restraint use and of differences between them. They informed there are not any forms of enablers or restraint currently in use, which was confirmed by the manager. All interviewed were aware of documentation required when enablers or restraints are used. According to the restraint register the last two uses of restraint were for residents who were subsequently moved to another level of care. Both instances were prior to the current manager's arrival.</p> <p>The facility manager/restraint coordinator demonstrated a sound understanding of the organisation's policies, procedures and practice and her role and responsibilities.</p> <p>A section of the quality and risk and of the staff meeting agenda is a reminder to cover any restraint use, or comment on challenging behaviours.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.1.1 The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.	PA Low	The purpose, values and goals of Dixon House are documented in both a business and a quality and risk plan. Both plans refer to Dixon House providing hospital level care. The facility manager has completed a stocktake of current resources at the facility and provided a basic plan that includes an overview of what is required for Dixon House to provide residents with hospital level care. During interview the manager was able to describe specific considerations for this to happen. However, at the time of audit a detailed and time-framed transition plan for Dixon House was not available.	A detailed and time-framed transition plan for Dixon House to provide hospital level care has not yet been completed and documented.	Provide a detailed and time-framed transition plan for Dixon House to provide hospital level care. 60 days
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and	PA Low	A previously raised corrective action in relation to accident and incident data not being analysed to identify trends and opportunities for improvement has been fully addressed with all such required analysis occurring, opportunities for improvement being identified and links being made through to a national benchmarking programme. Likewise for infection related data, which is also being analysed and benchmarked at a national	The health and safety component of the quality and risk management system is not being implemented as per the documented plan. Also not all quality and risk	Demonstrate that all components of the quality and risk management system, including health and safety, is analysed and evaluated for quality improvement purposes.

<p>evaluated and the results communicated to service providers and, where appropriate, consumers.</p>		<p>level with similar aged care services.</p> <p>A review of the wider quality and risk management system found that the analysis of other aspects of quality and risk were not being included in these processes. Staff meeting minutes reported numeric data from complaints, surveys, internal audits and some clinical outcomes; however there was no evidence of such data being analysed, nor of any conclusions identified that would contribute to quality improvement processes. There was also a lack of evidence of consistent reviews of the documented health and safety systems. These issues mean that the requirements for this criteria remain partially attained, albeit the focus is different.</p>	<p>related data is being analysed for quality improvement purposes.</p>	<p>180 days</p>
<p>Criterion 1.2.7.3</p> <p>The appointment of appropriate service providers to safely meet the needs of consumers.</p>	<p>PA Moderate</p>	<p>There are aspects of human resource requirements that are not fully meeting requirements and the previously raised corrective action remains open. The accounts person described the process that he and the Trust Board has been undertaking to rewrite the employment agreement to reflect the pay equity changes. As a result, the corrective actions under way to address the lack of signed employment agreements in staff files was placed on hold.</p> <p>Multiple staff training opportunities that cover mandatory training requirements are accessible to staff. Records sighted showed attendance is poor and tends to often include the same names. Certificates and training records in staff files are not up to date and are 'muddled' thus making it difficult to ascertain who has completed training requirements. Corrective action is needed to ensure requirements are met.</p> <p>In only a few months, the manager has gone through the orientation checklist with 10 of the 40 staff. New employees have undertaken the orientation programme and records are in their files. The remaining staff do not have records on file that demonstrated they have completed the orientation programme requirements or met the required competencies.</p> <p>The specific training, competencies and numbers of staff</p>	<ul style="list-style-type: none"> - Current signed employment contracts are not available in the staff files reviewed. - Staff files do not clearly demonstrate the training they have completed and it is unclear whether mandatory training requirements have been met. - Staff orientation records were not available in three of six staff files reviewed. - A detailed plan for staffing at Dixon House that would enable the safe delivery of hospital level care was 	<p>Ensure a detailed plan of staffing requirements for hospital level care is provided; all staff have a signed employment agreement; all staff have demonstrated their knowledge / competence of orientation programme topics and staff have undertaken the mandatory training requirements.</p> <p>60 days</p>

		required to enable safe hospital level care have not yet been fully identified and documented in a transition plan.	not available.	
<p>Criterion 1.2.8.1</p> <p>There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>	PA Low	<p>The rosters for the rest home consistently ensure safe service delivery. Registered nurses are currently on duty for Monday to Friday morning shifts at a minimum. A registered nurse is on call at all times.</p> <p>During interview, the manager described plans for employing additional staff for Dixon House to be able to provide hospital level care and informed she was aware of the need to have registered nurse cover on all shifts for hospital level care. Although the manager stated staffing is to be a component of the formal transition plan that is currently under development, as noted in 1.2.1, this was not yet available.</p>	There was no documented plan available to demonstrate how the service provider will ensure that a registered nurse will be available 24 hours of every day, and that there will be sufficient staff available, to meet the requirements of providing hospital level care.	<p>Provide a detailed staffing plan, which includes the rostering of a registered nurse for 24 hours of each day, to ensure hospital level care residents would receive safe service delivery.</p> <p>Prior to occupancy days</p>
<p>Criterion 1.4.7.3</p> <p>Where required by legislation there is an approved evacuation plan.</p>	PA Low	<p>A copy of the service provider's evacuation plan, with evidence that it included the newest wings was provided and reviewed. The local council noted on the building warrant of fitness that there is an evacuation plan. However, on the day of audit the letter of approval from the fire service of the fire evacuation plan was unable to be found and it was not possible to know if it covered hospital level care residents.</p> <p>Evidence of previously completed evacuation trials in a compliance records folder and in staff training records were sighted. The internal audit schedules notes evacuation drills are to be undertaken twice yearly. Although staff stated there has been a trial evacuation, the last record of such a trial was dated August 2016.</p>	The fire service letter of the approved fire evacuation plan was not available. Records for the last fire evacuation drill were also not available.	<p>A copy of the approved evacuation plan, which includes hospital level care provision, is required, as is evidence that six monthly evacuation drills are being completed.</p> <p>Prior to occupancy days</p>

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

No data to display

End of the report.