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 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:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 9 October 2018 End date: 10 October 2018

Proposed changes to current services (if any): The service provider has requested a reconfiguration of services that will enable the use of five double rooms by couples, rather than one resident only, which they are currently certified for. This will increase the potential bed numbers by five from 37 to 42.

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

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 provides rest home and hospital level care for up to thirty-seven residents. The service is operated by a Trust composed of representatives from four local churches and the community. It is managed by a clinical/facility manager with assistance from a clinical nurse manager. Residents and families spoke positively about the care provided.

This certification audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family, management, staff, contracted allied health providers, and a general practitioner.

Requirements for a reconfiguration of services in relation to five double rooms meet requirements. These five rooms will be able to be used for rest home level care couples.

This audit has resulted in a continuous improvement rating for the implementation of continuous quality improvement initiatives relating to corrective actions or quality improvement opportunities that are identified. Significant improvements have progressively occurred around care systems and for residents. There were no areas identified as requiring corrective action.

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.

Residents and family/whānau receive information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights which were seen to be respected. Services are provided that support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful and dignified manner.

Open communication between staff, residents, and family/whānau is promoted, and confirmed to be effective. There is access to interpreters if required. Staff provide residents and family//whānau with the information they need to make informed choices and give consent.

While there are currently no residents who identify as Māori there are provisions to meet their needs in a manner that respects their cultural values and beliefs. There is no evidence of abuse, neglect or discrimination.

The service has links with a range of specialist health care providers to support best practice and meet residents' needs.

A complaints register is maintained with complaints resolved promptly and effectively. Information about how to make a complaint is readily accessible. The clinical/facility manager is responsible for the management of complaints.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.

A business plan includes the scope, direction, goals, values and mission statement of the organisation. The clinical/facility manager provides reports to the governing body every two months. The facility is managed by an experienced and suitably qualified manager who is a registered nurse with management experience.

A quality and risk management system is implemented with support from a quality consultant. This includes an annual calendar of internal audit activity, monitoring of complaints, incidents, health and safety, infection control and restraint minimisation. Collection, collation and analysis of quality improvement data is occurring and is reported to the quality and staff meetings. Discussion of trends and follow up actions are undertaken where necessary. Meeting minutes, graphs of clinical indicators and benchmarking results are displayed in the staffroom. Adverse events are documented on accident/incident forms and opportunities for improvement are identified. 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 strategies for mitigation of these are in place. The hazard register is up to date.

A suite of organisational policies and procedures cover the necessary areas, are reviewed regularly and were current.

Human resources policies and procedures are based on current good practice and guide the processes for the recruitment and appointment of staff. A comprehensive orientation and staff training programme ensure staff are competent to undertake their role/s. There is a systematic approach to identify, plan, facilitate and record ongoing training, which supports safe service delivery. Annual individual performance reviews are completed.

Staffing levels and skill mix meet contractual requirements and the changing needs of residents. The manager or another registered nurse are available on call out of hours.

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.

The registered nurses develop, review, update and evaluate residents' care within required timeframes and according to resident's needs. Residents and their family/whānau have input into the development and review of their care plans. Residents and their family/whānau interviewed expressed they were satisfied with the care provided by staff.

There is an activities programme suitable for the needs of those living at Dixon House and residents are free to choose which activities they wish to participate in. One-to-one and group activities are provided by the sole diversional therapist who is assisted by a group of volunteers.

A paper-based medication system was in place with medications delivered monthly in blister pack form. The staff interviewed were aware of their responsibilities and had current medication competencies. Weekly and six-monthly stock checks of controlled drugs was evidenced with accurate entries and appropriate storage.

Food, fluids and nutritional needs of the residents are provided in line with nutritional guidelines for the older person. Special diets and requirements were being met. A nutritional profile is completed on admission and given to the kitchen staff with evidence of six-monthly reviews. Residents and family/whānau interviewed felt the menu was varied and meals provided were of a satisfactory standard.

Safe and appropriate environment

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

Implemented policies guide the management of waste and hazardous substances. Protective equipment and clothing are provided and used by staff. Chemicals, soiled linen and equipment are safely stored.

All buildings and plant comply with legislation and a current building warrant of fitness was displayed. A preventative and reactive maintenance programme is implemented.

The facility has been purpose built. There are single and double rooms including some with ensuite bathrooms and some with adjoining toilets. All are of adequate size to provide personal care to residents.

Communal areas are spacious and maintained at a comfortable temperature. Safe external areas with seating are available.

All laundry is undertaken onsite, with internal audit systems in place to monitor and evaluate effectiveness.

Emergency procedures are documented and displayed. Regular fire drills are completed and there is a sprinkler system installed in case of fire. An emergency power source is available. Residents reported a timely staff response to call bells and staff demonstrated an awareness of security requirements.

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.

The organisation implements policies and procedures that support the minimisation of restraint. Restraint is only used as a last resort when all other options have been explored. Staff receive training at orientation and thereafter every two years. Topics cover all required aspects of restraint and enabler use, alternatives to restraint, monitoring of restraint use and dealing with difficult behaviours.

Three restraints were in use at the time of audit. Comprehensive assessment, approval and monitoring processes are occurring for these. All restraint and enabler use, and their management processes, are reported through the quality and risk monitoring system.

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.

The infection prevention and control programme, led by an experienced and trained infection control coordinator, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education.

Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action is taken as and when required.

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	50	0	0	0	0	0
Criteria	1	100	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The Code of Health and Disability Services Consumers Rights (the Code) is included in the admission pack and is available at the front entrance in brochure form. Staff and family/whānau interviewed were familiar with the Code. Staff could state examples of the rights and how they could apply these in everyday situations, for example, knocking before entering a resident's room (respect), keeping doors and curtains closed while personal cares were attended to (dignity). Training on the Code is included in the orientation for all staff employed and in on-going education.
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	Informed consents were sighted in all files reviewed and covered photographs, gathering of information, display of information at the front entrance, van outings, and flu vaccination. Residents were able to make informed consent regarding their care. Specialised consent was obtained when a catheterisation was required. Residents interviewed confirmed that staff ask permission as and when required for personal cares and choice of day activities. Advance directives around resuscitation preferences, most of which were medically directed, were in the residents' files reviewed. There were no advance care plans in the files reviewed.

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 and support are available through the Advocacy Service and residents/family/whānau were aware of the service and how to access this and their right to have a support person. Information was provided as part of the admission pack and was also available at the main entrance. Staff interviewed were aware of the residents' right to have a support person if a relative is not available.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents are encouraged to maintain links with the community by such things as remaining under their GP and attending appointments at the medical rooms (with nursing staff phoning for appointment notes). Residents were noted to attend 'stroke groups', church, entertainment or optician and audiology appointments with their usual providers. Dixon House has open visiting hours and all family/whānau spoken to felt welcome when visiting.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints/concerns policy and associated forms meet the requirements of Right 10 of the Code. The information is provided to residents on admission and there is complaints information and forms available at the front entrance to the facility and from the office. The complaints register reviewed showed that five complaints have been received over the past year and that actions taken, through to an agreed resolution, are documented and completed within the timeframes specified in the Code. Action plans reviewed showed any required follow up. Documentation related to two examples of quality improvements having been initiated following complaints were sighted. The clinical/facility manager is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. Caregivers informed they would seek assistance from the manager or a registered nurse. There have been no complaints to the Health and Disability Commissioner since the last audit.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Residents interviewed were aware of the Code and have access to an advocate for the Nationwide Health and Disability Advocacy Service (Advocacy Service) living in the village flats. Information about the Code is provided at admission and is further discussed at residents' meetings. Several posters of the Code were sighted around the facility in such places as the lounge/dining room, nurses' station and outside the manager's office. Contact information for the Advocacy Service was available for the residents at the main entrance, along with complaint and feedback forms. At the main entrance there is a

		board with room numbers which residents have signed consent to have this information displayed.
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	Family/whānau interviewed verified that the residents received services in a manner that preserved their independence, values, beliefs, cultural, and social needs. Review of residents' files confirmed that personal preferences, beliefs, and cultural values were documented on admission and were used to develop a personalised care plan. The care plans documented residents' current abilities and interventions to maximise independence. Staff were observed knocking on doors before entering, maintaining privacy and respecting individual beliefs and values. Residents and family/whānau reported that they had not witnessed any harassment or abuse and neglect. Staff were aware of the policy on abuse and neglect, including what steps to take should there be any signs.
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 one resident who has a heritage of Māori culture but chooses to align with western cultures; however, there was a large extended family that was able to be accommodated in his generous sized room. The Māori plan and ethnicity awareness policy and procedure describes the four principles of Te Whare Tapa Wha, and notes that those who identify as Māori need to have a designated contact person to be involved in care plan consultations and other key areas where cultural issues require support/clarification. Links to Māori words – te reo, glossary of terms, and lists of key Māori health providers in the community are also included.
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	Information gathered from new residents on admission includes personal preferences, values, beliefs, and information regarding cultural needs. These were then used to develop personalised care plans. Resident satisfaction survey and interviews with family/whānau confirmed that residents' needs were being met. The education plan showed biennial cultural training for staff covering general cultural considerations and cultural aspects of death in relation to a range of cultures/ethnicities.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or	FA	Staff interviewed were able to explain the residents' rights regarding any form of discrimination, harassment, coercion, sexual, financial or other exploitation. Family/whānau interviewed revealed they had not witnessed any form of discrimination or harassment.

other exploitation.		
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	Management support good practice by providing opportunities for professional development, such as quality seminars and aged care conferences. The district health board (DHB) offer training days on specialised areas, including palliative care and syringe driver training. External support is sought through dietitians, physiotherapists and wound nurse specialists. The general practitioner (GP) reported that referrals were sent in a timely manner and staff were responsive to medical requests.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Resident/family/whānau interviewed confirmed that information about changes in health status, or incidents/accidents and outcomes of medical reviews were reported, according to their requests. On admission, family/whānau are asked when they wish to be contacted, for example, anytime, during the day or only for major events. Family/whānau records are used regularly to update next of kin, as observed in files reviewed of 10 residents. An 11th file, as noted in the figures above, was to extend the sample for an aspect requiring further review. Open disclosure is practised and family/whānau confirmed that staff and management were approachable and responded to concerns. Interpreters are available through the DHB but have not been required. Signage was observed on some residents' rooms reminding staff/visitors of sight/hearing impairment.
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 operates under the management and ownership of a Trust made up of representatives from four churches – Anglican, Methodist, Catholic and Presbyterian, plus four community representatives. A board member was interviewed and provided a copy of the business plan. The business plan was viewed, and although overdue for review, the board member assured the auditor that due to the length of time it had taken to establish the hospital care beds, the content and goals remain unchanged. This document outlines the purpose, values, scope, direction and goals of the organisation. Annual and longer-term objectives and the associated operational plans are included. The clinical/facility manager provides a report to the board about operational issues every two months and copies of these were viewed, as were board meeting minutes. All documentation showed adequate information to monitor performance is reported, discussed and reviewed. The mission statement refers to fulfilment, wellbeing and the whole person; emotional/mental, physical and spiritual. Philosophy statements note the residents' rights to be safe, lead an active life, be treated as individuals and be valued. They include the need for ongoing community integration and for independence to be encouraged.

		The service is managed by a clinical manager otherwise known as the facility manager. She is suitably skilled and experienced for the role and has responsibilities and accountabilities defined in a position description and an individual employment agreement. A separate person has the title of clinical nurse manager. The clinical/facility manager is a registered nurse who has been in the role at Dixon House for just over one year. This person has had extensive experience in various management roles within the DHB setting. Her professional development record shows she has attended multiple training sessions, courses, seminars and conferences related to leadership, management, improving and maintaining her clinical skills and in aged care. The clinical/facility manager is supported by a team of registered nurses, a board with long term membership and a quality consultant. An intention to reconfigure beds was reviewed during the audit. There are five purpose-built double bedrooms in a newer wing that have previously only been counted in the certified bed numbers as single bedrooms for one resident. At the last surveillance audit, these rooms were assessed as being suitable for dual purpose – rest home or hospital level care. Review of the rooms at this audit confirmed they are of sufficient size and configuration to enable 'couples' requiring rest home level to be accommodated in them; or for one person only receiving hospital level care. They are not set up with individual call bell systems, nor screening therefore are not suitable for two people unknown to each other; a rest home and a hospital level care couple nor two hospital level care people. The manager was clear that there was no intention at this time to modify the rooms for such a purpose as they just wanted to be able to use them for rest home level care couples without appearing to go over the certified bed numbers. The service provider holds contracts with the district health board (DHB) under the Aged Related Residential Care Agreement (ARRC) to provide rest home and hospital level care and support services, including hospital – medical (non-acute). Hospital level care has been available since the unannounced surveillance audit undertaken in November 2017. The reconfiguration will mean the number of hospital level/rest home (dual) beds remains at 20 but there are now a possible 42 rest home care beds. The 17 rooms in the Dixie wing remain unsuitable for hospital level care. At the time of audit, 33 beds were occupied by residents receiving rest home level care and four others were hospital level care, one of whom was receiving palliative care. One bed is used for respite care.
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	FA	A now retired previous clinical nurse manager has in the past relieved for the clinical/facility manager in her absence. The clinical/facility manager advised that plans are underway to continue to use this person in an advisory capacity while upskilling one of the senior registered nurses in leadership management skills to take on this role in the future. A second registered nurse is also able to do this, especially for short term absences, should the need arise. According to the clinical/facility manager, the designated person would carry out the required duties under delegated authority. Members of the board are also available as necessary.

timely, appropriate, and safe services to consumers.		During absences of key clinical staff such as the clinical nurse manager, the clinical management is overseen by the clinical/facility manager, who is also a registered nurse, experienced in the sector and able to take responsibility for any clinical issues that may arise. Staff reported they are confident the clinical//facility manager would always ensure a suitable person is available to manage the service.
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.	FA	The quality assurance and risk management programme with its own objectives and action plans is outlined within the policy documentation. Use of the quality framework of 'Plan, Do, Study, Act' is described alongside the quality strategy, which notes the organisation's commitment to continuous improvement and risk management. Responsibilities of the quality manager (clinical/facility manager) and the quality improvement and risk committee are described. The quality and risk management committee meet every two months and includes representation from the kitchen, cleaning staff, caregivers and registered nurses. A document control policy states that all policy and procedure documents are developed in draft by a contracted nurse management consultant who ensures the documents are controlled. The document control system ensures a systematic and regular review process, referencing of relevant source and approval of documents for use. Staff are updated on new policies, or changes to policies, through staff meetings and through copies being left in the staffroom for staff to sign as read. Policies reviewed cover all necessary aspects of the service and contractual requirements and all reviewed were current. There are appropriate references to the interRAI Long Term Care Facility (LTCF) assessment tool and process. The quality programme includes an internal audit matrix, which details a range of organisational monitoring systems and quality assurance processes. This includes management of incidents and complaints, audit activities, a regular resident and family satisfaction survey, monitoring of outcomes, clinical incidents including infections and restraint use. The matrix is being adhered to and corrective action processes implemented. Corrective actions and identified quality improvement opportunities are demonstrating continuous quality improvement. Not only are these quality improvement processes being consistently strengthened but improvement is occurring for residents, and around care systems, resulting from positive and measurable changes made. There is a separate health and safety manual that is a component of the wider quality system. The manager is familiar with the Health and Safety at Work Act (2015) requirements and a new health and safety officer, who was trained up by her predecessor, has been appointed. The clinical/facility manager is arranging for her to attend relevant external training. Terms of reference and meeting minutes reviewed confirmed adequate reporting systems and discussion occurs on quality matters. Regular review and analysis of quality indicators occurs, and related information is reported and discussed at the quality and risk management team meetings and at the two monthly staff meetings. Minutes reviewed include discussion on pressure injuries, restraints, falls,

		complaints, incidents/events, infections, audit results and activities. Staff reported their involvement in quality and risk activities through signing they have read the quality related documents including updated policies, involvement in internal audits and completion of relevant forms such as for incidents/accidents. Resident and family surveys are completed annually. The last survey showed overall satisfaction with services provided alongside concerns around the gardens and food. Both issues of concern have been rectified. The clinical/facility manager described the processes for the identification, monitoring and reporting of risks and development of mitigation strategies. A hazard register and a risk register show consistent review and updating of identified risks and the strategies to mitigate them. The risk management plan was last reviewed and updated in February 2018.
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.	FA	Policy and procedures described essential notification reporting requirements for specific issues that arise in relation to severe and major categorised incidents including pressure injuries, accidents, human resources, infection control and the coroner, for example. The facility manager advised there had been no notifications of significant events made to the Ministry of Health or the DHB since the previous audit. However, follow-up to a current event, which was already being monitored, occurred during the audit. Relevant documentation was completed and forwarded to authorities. The issue was unrelated to the audit. Policy documents described the investigation processes for accidents and incidents and a flow chart illustrates the process. Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed. The actions were followed-up in a timely manner. Open disclosure is occurring when indicated. Adverse event data is collated, analysed and reported to the quality and risk management meetings. Meeting minutes reviewed show discussion in relation to trends, and relevant action plans are developed and improvements made. Copies of the reports, including graphs, are posted on the staffroom wall and staff are encouraged to read them. Two staff expressed positivity about having access to this information. Dixon House has access to a quality consultant who uses the data for external benchmarking purposes, which is enabling the service provider to select priorities for actions. Examples included development of quality improvement projects as noted above in standard 1.2.3 of the report.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in	FA	Policies and procedures, in line with good employment practice and relevant legislation, guide human resources management processes. Position descriptions reviewed were current and defined the key tasks and accountabilities for the various roles. The recruitment process includes referee checks, police vetting and validation of qualifications and

accordance with good employment practice and meet the requirements of legislation.		practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are now being consistently implemented and records are systematically maintained. Current annual practising certificates were sighted for a range of health professionals including pharmacy, GPs, the podiatrist, dietitian, physiotherapist and enrolled and registered nurses. Where recruitment documents such as evidence of police vetting or staff interview records were absent, this reflected their length of service as there was not previously the requirement to retain these documents. As in Standard 1.2.8, there are currently trained and competent registered nurses who are maintaining their annual competency requirements to be able to undertake interRAI assessments. Two more are scheduled to undertake this training in November. Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role and included support from a 'buddy' through their initial orientation period. Records reviewed in staff files showed documentation of completed orientation. Performance reviews are now completed after a three-month period and annually thereafter. Not all staff had a current performance appraisal in their file; however, the manager provided a list of staff and the status of these. Most of these staff were due for their appraisal in August or September, as they were all brought up to date at this time a year ago when the manager commenced. The manager has completed her initial section of the 2018 appraisals, passed them to the staff members and is waiting on them to complete their section. Other examples were that the staff had returned them (sighted) and were awaiting their final appointment time with the manager to discuss the comments and sign them off. Continuing education is planned on an annual basis. Mandatory training requirements are defined and scheduled to occur over the course of the year. Education records reviewed demonstrated completion of training, what training was provided and who provided it. Staff are followed up if they have not attended required topics and alternative forms of training are offered. Care staff have either completed, commenced, or are being enrolled in a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. The staff member who was the internal assessor for the programme has left the service and a new person is being upskilled for the role. Email confirmation of this plan was sighted. Staff informed they have access to external training opportunities as relevant and examples of these were on staff records.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled	FA	There is a documented rationale for determining staffing levels and skill mixes to provide safe service delivery. The facility adjusts staffing levels to meet the changing needs of residents, although the manager informed that this has seldom been necessary as the number of hospital care residents remains low. Casual pool staff are available for any changes in resident acuity levels and for replacing staff absences.

and/or experienced service providers.		A registered nurse is on duty 24 hours a day on seven days of the week to ensure contractual requirements are met for hospital level care. The minimum number of staff is provided during the night shift and consists of one registered nurse and one enrolled nurse, or caregiver. With the assurance of a registered nurse now on all shifts, staff expressed confidence that sufficient advice and support is available when required. The manager, who is also a registered nurse, or her replacement when on leave, is available on call after hours but commented that this is seldom/almost never required. There has been a recent review of staff allocation since the commencement of hospital level care and following extensive staff consultation, which has seen a move to a four on and two off rotating roster for full time workers. Care staff interviewed were reluctant to comment on the adequacy of staffing levels due to the recency of staffing and rostering changes, but stated they are completing the work required. The manager informed of plans in the next few weeks to work several shifts caring for residents to get a better view of staffing levels, and how staff are operating, since the roster changes. Residents and family members interviewed informed that staff are always busy but 'they are excellent and can't do enough for the residents'. Observations and review of eight weeks of rosters confirmed adequate staff cover has been provided and replacements accessed when required. Staff files and training records demonstrated that a senior caregiver maintains her first aid certificate as do the van drivers, the enrolled nurse and the diversional therapist. All registered nurses have a current cardio pulmonary resuscitation competency (DHB) and/or a current first aid certificate. Two of the five registered nurses have a current interRAI competency and a further two registered nurses are scheduled for this training in November.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	Files reviewed showed evidence of uniquely identifiable labels. All reviewed were current, orderly, and integrated with documentation from GP, allied health professionals including a podiatrist, dietitians, mobility assistant and activities staff. All records showed the date, signature and designation of the writer. Files are stored in the nurses' station with the door locked when no staff are present. Archived notes are stored securely on site for the recommended length of time and were retrievable if required.
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	FA	The admission process is clearly laid out in the policies and procedures. The process includes the admission agreement and an admission checklist as well as a welcoming tour of the facility, residents' room, menu sample, time frames and monitoring. Once a potential resident, assessed by the Complex Clinical Care Network Service (CCCN) and level of care has been identified, the family are able to look for a suitable facility. The family are invited for a tour

services has been identified.		and receive an information pack including the Code and Advocacy Service pamphlets. On the day of admission, an RN is assigned to them for the day, to welcome new arrivals, get paperwork signed, and gather information for an initial care plan. A facility tour and introduction to staff and other residents follows. Families and residents interviewed reported that they received sufficient information and felt welcomed. Files reviewed contained completed demographic details, assessments and signed admission agreements in accordance with contractual requirements. A detailed initial care plan was formulated. Pharmacy, GP, kitchen and laundry providers were informed of the new resident.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	On the day of audit, a resident was transferring to hospital for some routine surgery. The DHBs 'yellow envelope' included, next of kin details and transfer note detailing care needs, mobility, cognitive function, allergies, communication and a copy of the medication chart and enough medications for 24 hours. The resident's next of kin was transporting the resident but the RN said an escort could be arranged if required. A verbal handover to the hospital was documented in the progress notes.
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.	FA	A paper-based medication system was in place on the day of audit. The medications are delivered monthly in blister pack form, from a contracted pharmacy. They are checked against the medication chart by an RN and an enrolled nurse (EN) and stored in a locked cupboard until use. All non-packaged medications are kept in individual 'cubby holes' in a locked cupboard. All medication sighted was within current use by date. Clinical pharmacist input is provided on request, including holding education sessions. The medication management policy was current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. The GP reconciles medications during the first 48 hours after admission and ensures they are charted. The staff observed during a medication round demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage. The drug competency register was sighted and is updated annually. Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six monthly stock checks and accurate entries. Specimen signatures were sighted. The records of temperatures for the medicine fridge reviewed were within the recommended range.

		Good prescribing practices noted included the prescriber's signature and date recorded on the commencement and 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 were seven residents self-administering medications at the time of audit. Appropriate processes were in place to ensure this was managed safely. Assessments, competency and review were signed by the GP. There is an implemented process for comprehensive analysis of any medication errors. No medication errors had been reported.
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	The food service is provided on site by a kitchen team made up of two cooks and a team of kitchen hands. The menu is on a summer/winter four week rotating cycle. The menu was last reviewed by a dietitian on 10 January 2017 and recommendations made were put in place. A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements and allergies are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, such as lipped plates are available. On the day of audit, residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided. Evidence of registration of the food plan was not available, although the manager informed this had been presented to the council and they are awaiting a reply. Meantime, the food plan from the contracted quality consultancy is in use and ensuring 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 as part of the plan. There was evidence of compliance with the cleaning schedule and kitchen staff are included in hand washing competencies. The food services manager has undertaken a safe food handling qualification, with some kitchen assistants completing relevant food handling training. Plans are in place for the remaining kitchen staff to undergo an online training course when it becomes available, as there are no other relevant training options available in this region.
Standard 1.3.2: Declining Referral/Entry To Services	FA	The nurse manager interviews potential residents and assesses the suitability of Dixon House for their care. Things to be considered are acuity of care, staff to resident ratio, if there are any special needs,

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.		and if their needs would best be meet there. A record is kept of any decline and documents filed. Should a resident's needs change they are required to be reassessed by the CCCN. A new placement is then found with support from the CCCN and family.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Assessments are completed using a variety of validated nursing assessments such as Coombes, Braden, nutrition profile and pain scale. These are used to formulate an initial care plan. The information obtained from these initial assessments, combined with triggers and outcomes from interRAI assessments is used to formulate the long term care plan (LTCP). Files reviewed showed interRAI assessments completed by one of the interRAI trained assessors, were current and up to date. Family/whānau interviewed confirmed they were included in the formulation and evaluation of LTCPs.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Care plans reviewed reflected the needs of the resident and appropriate interventions to meet these. Needs identified by the interRAI assessment were incorporated in the writing of the plans. Residents and family acknowledged that they were involved in planning care. Long term care plans are made up of safety/risk, mobility, continence, diet, medication, pain, sleep/comfort, intimacy, communication, cognitive function, behaviour management, respiratory/cardiac, spiritual/cultural, skin/pressure risk, with input from relevant staff. Any change in intervention is documented and passed on to staff at handover through both written and verbal means.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Documentation, observations and interviews verified that provision of care to residents is consistent with their needs, goals and the plan of care. Residents confirmed that they had input into each day's care and activities. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. Staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs. Pressure relieving cushions and mattresses were available. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders were followed, and care is professional.
Standard 1.3.7: Planned	FA	The activities programme is provided by one staff member, currently undergoing training for the national Certificate in Diversional Therapy and rostered volunteers. She has been in the role since June 2018 but

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.		has relieved in the past. A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated as part of the formal six monthly care plan review. Activities reflected residents' goals, ordinary patterns of life and included normal community activities. A monthly calendar is delivered to each room and notice boards around the facility and includes such things as quizzes, Tai Chi, church services, knitting circle, games and a shopping trolley as well as van outings. Individual, group activities and regular events are offered. Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings. Residents interviewed confirmed they find the programme satisfactory.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Residents' care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN and handed over to the next shift. Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change, according to policy and procedures. Of the ten files fully reviewed, eight had regular evaluation occurring and demonstrated family involvement. The other files had not reached the six month time frame. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans being consistently reviewed and progress evaluated as clinically indicated were noted for a urinary tract infection. When necessary, and for unresolved problems, long term care plans are added to the long term care plan. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.
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	Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a 'house doctor', residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to the dietitian and physiotherapist. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate. The GP interviewed said he was available until 8 pm and then the GP at the hospital was on call overnight.

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	Documented processes for the management of waste and hazardous substances were in place. Infection control documentation includes a waste management section detailing procedures for waste (blood and bodily fluids) management and disposal. The waste disposal policy covers weekly collection by a contractor, residents' rooms, kitchen, medicine and medical waste, cultural sensitivity and liquid waste. Practices around these were checked and were consistent with the policy. The maintenance person takes cardboard recycling to the local refuse station. A chemical use/supply/storage and safety policy and procedure was sighted and describes a commitment to keeping residents safe. There has been a recent review of chemical storage following an internal audit. The doors to the areas storing chemicals were secured and containers labelled. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored. Staff interviewed knew about the associated risks. There is a policy and procedure on personal protective equipment provision. Protective clothing and equipment were available. Staff were observed using plastic aprons and gloves.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	A current building warrant of fitness that expires 1 July 2019 is publicly displayed. Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose. There is a proactive and reactive maintenance programme and buildings, plant and equipment are maintained to an adequate standard. A maintenance book for the recording and follow-up on maintenance tasks and records showed these are appropriately actioned. The testing and tagging of equipment and calibration of bio medical equipment are current as confirmed in documentation reviewed (next due September 2019), interviews with a contracted maintenance person and observation of the environment. A vehicle check is undertaken regularly, and the facility van had a current warrant of fitness, registration and suitable first aid kit. There are several courtyard areas with suitable seating. External areas are safely maintained and are appropriate to the resident groups and setting. The front entrance is level entry and there are low ramps at other external doors to make entry and exit more accessible. Resident and family survey feedback had identified that the garden had become untidy and poorly maintained. This has since been rectified with two gardeners employed. Residents confirmed they are pleased with the change. The environment was hazard free and residents are safe. Staff and rest home residents interviewed confirmed they know the processes they should follow if any repairs or maintenance are required.

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 adequate numbers of accessible bathroom and toilet facilities throughout the facility. These include full ensuites in some rooms, an adjoining toilet and hand basin in others and some just have a hand basin. Sufficient numbers of communal showers and toilets are available, and one area has a bath. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote resident independence. Hot water temperatures are reviewed monthly and records sighted show they are at a safe temperature. A health and safety audit identified that the shower lining in one area requires repair and documents sighted showed this process is under way.
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	Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. There has been a recent effort to encourage de-cluttering of the floors in residents' rooms as part of an initiative to reduce the number of falls. Rooms are personalised with furnishings, photos and other personal items displayed. Bedrooms provide single accommodation, although there are five double rooms. The only room that is currently shared is occupied by a married couple. Staff and residents reported the adequacy of bedrooms. It was found that when a couple went into one of five double rooms built with the intention of having two people in them, that it pushed the service above its certified bed number. These rooms are of sufficient size and configuration to accommodate two rest home level care people who identify as a 'couple'. They are not suitable for one or both members of the couple to receive hospital level care, or for two 'single' residents, as there neither a dual call bell system, or screening to ensure privacy. One single resident may receive hospital level care in these rooms as was identified at the surveillance. There is space to store mobility aids walking frames and wheel chairs. Mobility scooters are stored in a designated garage area outside and do not impede walkways or create a hazard for mobile residents.
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	Communal areas are available for residents to engage in activities. A favourite area for some residents is a downstairs conservatory, which has adequate seating. The dining and lounge areas are spacious and enable easy access for residents and staff. These two areas can be divided for activities when required. Residents can access areas for privacy, including a telephone booth and other small seating areas, as desired. Furniture is appropriate to the setting and resident needs. It is arranged in a manner which enables residents to mobilise safely.

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	Detailed laundry and cleaning policies and procedures are available, as are cleaning schedules for everyday cleaning and for spring cleaning. Manuals with instructions and material data sheets for cleaning and laundry chemicals are also available. All laundry, including residents' personal items, is undertaken on-site in one of the two dedicated laundry areas. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner. Evidence of two historical complaints having been received regarding the laundering of personal items had been satisfactorily resolved. The laundry is currently undertaken by care staff who demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Staff training records confirmed these processes are covered within their orientation. Two people are employed to undertake cleaning duties Monday to Friday with caregivers picking up basic tasks during weekends. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers. Cleaning and laundry processes are monitored through the internal audit programme, as well as monthly health and safety audits.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	Policies and guidelines for emergency planning, preparation and response are known by staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency. The manager described an open relationship with local emergency and civil defence personnel. The current fire evacuation plan was approved by the New Zealand Fire Service on 24 November 1997. Sprinklers and smoke alarms are installed. Records sighted confirmed a trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service. The orientation programme includes fire and security training. Training records confirmed staff have completed education on emergency management and participated in a trial fire evacuation within the last year. Staff noted their awareness of the emergency procedures. Adequate supplies for use in the event of a civil defence emergency, including food, blankets, mobile phones and gas BBQs were sighted and meet the requirements for the facility being at full occupancy. Water is stored behind the kitchen in large plastic containers that are dated when renewed. This task is undertaken by the maintenance person monthly. The maintenance person also tests the on-site generator every month and emergency lighting is tested regularly as part of the fire service checks. Call bells alert staff to residents requiring assistance. Although documentation was not found, three different staff members independently reported that call system audits are completed every four to six weeks as part of the health and safety audits. Random checks were undertaken during the audit. Copies of invoices for repairs of malfunctioning call bells demonstrated action is taken when required. Residents and families reported staff respond promptly to call bells. Appropriate security arrangements are in place. Doors and windows are locked automatically at a

		predetermined time and the facility is rechecked for security at the shift handover to night staff. All windows have security latches on them.
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 residents' rooms and communal areas have opening external windows. A mix of electric heating is provided with underfloor heating in the newest wings, a heat pump in the downstairs lounge/dining area, fan heaters in bathrooms and panel heaters throughout the facility. Additional portable oil filled heaters are available for residents' rooms if they feel cold. All areas were warm and well ventilated throughout the audit and residents confirmed the facilities are maintained at a comfortable temperature.
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 service implements an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual. The infection control programme and manual are reviewed annually. The enrolled nurse is the designated IPC coordinator, whose role and responsibilities are defined in a job description. Support is provided by the clinical nurse manager (CM) and facility manager (FM). Infection control matters, including surveillance results, are tabled at the quality/risk committee meeting. This committee includes the clinical nurse manager, the facility manager, the IPC coordinator, the health and safety officer, and representatives from food services and household management. Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours, not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities.
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	The IPC coordinator has appropriate skills, knowledge and qualifications for the role. The infection prevention and control position has been held for fifteen years by an EN, who has completed training each year from a variety of sources, such as DHB training days and online with Healthline. She has attended relevant study days, as verified in training records sighted. Additional support and information is accessed from the infection control team at the DHB, the community laboratory, the GP and public health unit, as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections. The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection.

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	There are written policies and procedures for the prevention and control of infections which comply with relevant legislation and current accepted good practice. The infection control programme and manual are signed off annually by the facility manager. Hand sanitiser was available round the facility for use of staff or visitors.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by the DHB infection and control advisor. A record of attendance was sighted of the last session held on 27 September 2018 on Norovirus. Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell and increasing fluids during hotter weather.
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	Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal infections and the upper and lower respiratory tract. The IPC coordinator reviews all reported infections, and these are documented and graphed. New infections and any required management plan are discussed at handover, to ensure early intervention occurs. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year, and comparisons against previous years. This is reported by the nurse manager at quality meetings.

		No outbreaks have been reported.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator, who is the registered nurse/clinical nurse manager, provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and her role and responsibilities. Restraint coordinator roles and responsibilities are described within the clinical nurse manager's position description. On the day of audit, three residents who were receiving rest home level care were recorded as using bedrails as a restraint. Although there were no enablers in use, a similar process is reportedly followed for the use of enablers as is used for restraints. This provides for a robust process which ensures the on-going safety and wellbeing of the resident. Staff confirmed during interviews that they were aware of the difference between a restraint and an enabler and the voluntary nature of the latter. The manager and the restraint coordinator noted that restraint is used as a last resort to assist with a resident's safety when all alternatives have been explored. This was evident on review of the quality and risk management meeting minute, in files reviewed of those residents who have approved restraints and from interviews with staff.
Standard 2.2.1: Restraint approval and processes Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.	FA	There is no separate restraint approval group; instead restraint management is undertaken by the quality team. Restraint review and reporting processes are part of the quality and risk management meetings. Review of quality and risk management meeting minutes, review of residents' files and an interview with the coordinator confirmed there are clear lines of accountability. All restraints have been approved, and the overall use of restraint is being monitored and analysed. Evidence of family/whānau/EPOA involvement in the decision making, as is required by the organisation's policies and procedures, was in all three files reviewed. Its use has also been discussed with the residents at their level of understanding. Use of a restraint or an enabler is included in the care planning process and documented in the plan of care. The GP had also been involved and signed the relevant authorisation forms.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is	FA	Assessments for the use of restraint were documented and included all requirements of the Standard. The initial assessment is undertaken by the restraint coordinator with input from the resident's family/whānau/EPOA. There was evidence that it had been discussed with the resident as relevant. The

undertaken, where indicated, in relation to use of restraint.		restraint coordinator described the documented process. Identification of the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks were evident in the assessment process. The desired outcome for each person was to ensure the resident's safety and security. Completed assessments were sighted in the records of the three residents who were using a restraint. The general practitioner is involved in the final decision on the safety of the use of the restraint.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	The use of restraints is actively minimised and the restraint coordinator described how alternatives to restraints are discussed with staff and family members. Time is spent explaining how the resident can be safely supported and suitable alternatives, such as the use of sensor mats or low beds are explored before use of a restraint is implemented. When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. This is included in the resident's care plan and monitoring forms reviewed recorded that this had occurred as required. All restraints currently in use are only used at night time with most records showing they are being removed at 7am when the morning staff are around. A restraint register is maintained, updated every month and records confirmed it is reviewed at each quality and risk management meeting. The register was reviewed and contained all residents currently using a restraint and enough information to provide an auditable record. Staff have received training in the organisation's policy and procedures and in related topics, such as positively supporting people with challenging behaviours. Staff spoken to understand that the use of restraints is to be minimised and any restraints used are to be used safely and with dignity and respect.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	Review of residents' files evidenced the individual use of restraints is reviewed and evaluated during care plan and interRAI reviews. Review forms in the files of the three residents for whom restraint is used showed all were current. There was evidence of family involvement. Quality and risk management meetings confirmed that restraint use had been reviewed for the individuals for whom it was authorised. The evaluation includes future options to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and documentation completed as required by the Standard.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of	FA	The quality and risk management team undertake a review of all restraint use at each two monthly meeting and the facility manager provides a summary of the review to the Board of Trustees. Information in relation to the various aspects of the Standard and of individual use is provided to the team by the restraint coordinator. Records of these sit within the quality meeting minutes and those reviewed confirmed the records include analysis and evaluation of the number, frequency and type of restraint use

their use of restraint.		in the facility. Information in restraint reports includes whether alternatives to restraint have been considered, the effectiveness of the restraint in use, the competency of staff, the appropriateness of restraint/enabler education and feedback from the doctor, staff and families. Six monthly internal audits on restraint use and management are undertaken and outcomes from these also inform the quality meetings. Any changes to policies, guidelines, education and processes are implemented if indicated. Data reviewed, meeting minutes and interviews with the facility manager and clinical nurse manager confirmed that the service provider has increased the focus on minimising use of restraints. The use of de-escalation and other strategies and techniques have been targeted to improve resident safety. The restraint coordinator provided documentation confirming that following review of a person earlier this year, a restraint that had been in use was no longer necessary and alternative management practices had been implemented.

Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
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.	CI	Over the past year, a registered nurse quality consultant has been assisting the manager and senior staff at Dixon House in the development of comprehensive quality or continuous improvement plans using the ‘Plan Do Study Act’ cycle. Five examples of completed initiatives were reviewed and demonstrated continuous improvement over time was occurring. Each initiative had been placed into a template that uses a ‘Smart, Measurable, Achievable, Relevant and Timeframe’ framework for development of the goals. Action plans were developed and the Plan Do Study Act framework sections were completed. The documentation for each initiative included an evaluation by asking what was learnt, what the improvement was, were there any further changes needed to improve the situation further and what timeframe the next review was due. The initiatives sighted had been developed following a complaint, an adverse event or a significant identified shortcoming. Examples that have been evaluated demonstrated there had been a notable improvement in the management of a person’s diabetes, which had improved the quality of life	Continuous improvement is evident in the manner that some of the more significant identified shortcomings, adverse events and complaints are being developed into comprehensive quality improvement initiatives. Corrective actions and identified quality improvements are investigated according to the Plan Do Study Act framework for continuous quality improvement. Assessment, actions and evaluation processes are undertaken for each identified issue. The subsequent evaluation outcomes are demonstrating additional benefits for individuals, groups of residents and progressive positive systems changes.

		for the person and positively changed systems within the service around managing people with this condition; changed handover systems had improved caregiver access to resident information and to records about the individual resident's care therefore ensuring more individualised care can be provided; strategies have been implemented to reduce the number of resident falls and six months of data is demonstrating success (this is ongoing); and a successful initiative was implemented to address residents' needs to love and to be loved with the introduction of a cat as a rest home pet. All initiatives identified unintended outcomes, mostly of a positive nature, in the evaluation summaries.	

End of the report.