

# Dixon House Trust Board (Inc) - Dixon House Rest Home

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## Introduction

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

The audit has been conducted by 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:

<b>Legal entity:</b>	Dixon House Trust Board (Inc)
<b>Premises audited:</b>	Dixon House Rest Home
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 14 October 2020      End date: 14 October 2020
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	38

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

Indicator	Description	Definition
	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 42 rest home and hospital level care residents, including for respite care. The service is operated by the Dixon House Trust Board and managed by a facility manager, who also operates as the clinical nurse manager. Residents and families spoke positively about the care provided.

This unannounced surveillance 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 and a general practitioner.

This audit identified two areas of improvements relating to the business plan and the temperatures of hot food. There were no areas identified as requiring improvement at the previous audit.

## 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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Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to interpreting services if required.

Residents and relatives are informed about the service provider's complaint process and their right to make a complaint. A complaints register is maintained with complaints 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 low risk.
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Reports on clinical indicators and key operational aspects of service provision are regularly delivered to the Dixon House Trust Board. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Electronic systems are now complementing paper-based ones to enhance data analysis and summary processes. Staff are involved and survey feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and are current and reviewed regularly.

The appointment, orientation and management of staff are based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

## Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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The multidisciplinary team, including a registered nurse and general practitioner, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents verified satisfaction with meals.

## Safe and appropriate environment

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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There is a current building warrant of fitness on public display. No modifications have been made to the building since the last audit.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The organisation has implemented policies and procedures that support the minimisation of restraint. Three restraints and no enablers were in use at the time of audit. A comprehensive assessment, approval and monitoring process with regular reviews occurs. Staff confirmed ongoing education on restraint and enabler use is provided and demonstrated a sound knowledge and understanding of the associated processes.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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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)
<b>Standards</b>	0	14	0	2	0	0	0
<b>Criteria</b>	0	37	0	2	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld.	FA	<p>A complaint policy and procedure are detailed within the organisation's policy manual and a complaints form is available. Copies are at the front door, which was confirmed during a staff interview. This documentation meets the requirements of Right 10 of the Code. The facility manager informed they provide information about the complaint process, both verbally and in writing, to residents and families on admission and those interviewed knew how to make a complaint.</p> <p>The complaints register reviewed showed that three complaints were received in 2018; zero in 2019 and so far in 2020 there have been three. All of the latest ones have been made within the last month, during or since an absence of the facility manager. Investigations are still underway for each and progress toward resolutions are underway. Updates are being provided within the required timeframes and the complainants are being involved in the resolutions. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from external sources since the previous audit.</p>
Standard 1.1.9: Communication  Service providers communicate	FA	<p>Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code of Health and Disability Services Consumers' Rights (the Code). The facility manager/clinical nurse manger or the care coordinator takes responsibility for open disclosure processes. 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 as well as outcomes of regular and any urgent medical reviews.</p>



<p>effectively with consumers and provide an environment conducive to effective communication.</p>		<p>This was confirmed in communication forms in residents' records reviewed and in completed incident forms.</p> <p>The facility manager/clinical nurse manager informed they have never needed to use an interpreter service but are aware the local West Coast District Health Board is able to access interpreters should one be required. An interpreter policy and procedures describe how to access the Foundation for the Blind, the Deaf Association, AAA – All Translations Service and Translations Worldwide. The facility manager has used large print for documentation for one person.</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>A business continuity plan was available for management of ongoing services at Dixon House in the event of an emergency, with a focus on Covid-19. However, there is not a current strategic or business plan that outlines the purpose, values, scope, direction and goals of the organisation and nor was there a copy of the previous one. This has been raised for corrective action as the former one had also not been formally updated at the time of the previous audit. Hence there was also no document that describes annual and longer-term objectives and associated operational plans. Copies of the 2020 Trust Board annual report and board meeting minutes for October 2020 included evidence of presentations of reports from the manager and the clinical advisor. These included topics on adverse events, incidence and management of infections, staffing, staff education, internal audits/compliance, pay parity for nurses, use of technology in the clinical field and a sector profile review.</p> <p>The facility manager who is responsible for the management of Dixon House has had over 40 years of experience as a registered nurse and been in the current role for just over three years. Responsibilities and accountabilities for the role are defined in a job description and individual employment agreement. The facility manager confirms knowledge of the sector, regulatory and reporting requirements and maintains currency through attending education on leadership and management, attending courses such as 'Walking in another's Shoes' and attending ARRC meetings every two to three months. Although the facility manager is also known as the clinical nurse manager, this latter role is shared with a care co-ordinator who is an enrolled nurse, has been at the facility for many years and has continually upskilled at every available opportunity.</p> <p>The service holds contracts with the West Coast District Health Board under the Age Related Residential Care Agreement to provide rest home and hospital level care, respite care and for end of life care. On the day of audit, twenty-two residents were receiving rest home level care, two of whom were under respite care and sixteen hospital level care.</p>
<p>Standard 1.2.3: Quality And Risk Management</p>	<p>FA</p>	<p>The organisation has a planned and documented quality and risk system that reflects the principles of continuous quality improvement. This has been established with the assistance of a quality consultant. Meeting minutes reviewed confirmed the facility manager's information that overviews of quality and risk issues are provided and</p>

<p><b>Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>discussion at two monthly quality and risk meetings, two monthly health and safety meetings and two monthly staff meetings, including departmental ones for household staff for example. Topics covered include accidents/incident reports, infection data and any related trends, complaints, satisfaction surveys, training, care related/clinical issues, restraint, staffing and education. Clinical data from these reports is analysed and actions taken for correction or improvement as relevant. Any required corrective actions identified during internal audits, or other review processes are managed in a coordinated manner to address the identified shortfalls. The use of electronic recording systems for quality and risk related data is increasing and is now used for internal audit records and follow-up corrective actions, incidents/accidents and infections. Benchmarking against similar facilities nationwide is able to be undertaken and assist the manager and staff in decision-making to improve service delivery.</p> <p>Staff reported their involvement in quality and risk management activities through reading policy documents, representing their staff group on health and safety and/or quality and risk meetings and cooperating with completing forms such as after an incident when things happen. A food survey has just been distributed as part of the planned actions to address one of the current open complaints. The annual 2020 family satisfaction survey has just been sent out, as they were delayed due to Covid-19 restrictions. An independent advocate has agreed to work with the residents to obtain their feedback. Although actions related to food, laundry services and activities were made following the 2019 surveys, the facility manager informed efforts to improve all of these services continues.</p> <p>Policies and procedures are also developed in consultation with a quality/ clinical consultant. Those reviewed cover the necessary aspects of the service and contractual requirements. Policies are based on best practice and are current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The facility manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager informed that a Health and Safety plan around Covid-19 was implemented during the key risk phases. A senior caregiver interviewed is a health and safety officer and works with the facility manager who is familiar with the Health and Safety at Work Act (2015). Minutes of regular health and safety meetings were viewed, the hazard register is updated six monthly and health and safety is included in the manager's reports to the Dixon House Trust Board.</p>
<p><b>Standard 1.2.4: Adverse Event Reporting</b></p> <p>All adverse, unplanned, or untoward events are systematically recorded by the</p>	<p>FA</p>	<p>Staff document adverse and near miss events on an accident/incident form. Copies of those reviewed were accompanied by completed falls assessment forms and neurological observations when indicated. The data for these incidents is transferred into an electronic system for incident records and a sample of incidents forms reviewed showed each had been investigated and followed up as per the electronic records. Action plans were developed and implemented accordingly for individual resident's events. Collective adverse event data is collated, analysed, graphed and results summaries developed. This information is compared against the industry average and reported to quality and risk and staff meeting minutes and review of the analysed data may result in further corrective or preventive action or identified as a quality improvement opportunity.</p>

<p>service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>The facility/clinical nurse manager described essential notification reporting requirements, including for pressure injuries. They advised there have been nine notifications of significant events made to the Ministry of Health since January 2019. These have primarily been related to having insufficient registered nurses being available to cover all shifts with three others relating to significant falls by residents.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes a formal initial interview, referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained. There is a folder of current annual practising certificates for the registered health professionals associated with Dixon House in their relevant capacity.</p> <p>Staff orientation includes all necessary components applicable to the specific role of each staff person. Orientation records in staff files confirmed checklists are completed for all newer staff, although such records were not necessarily available for some of the longer-term staff who commenced prior to the current facility manager. During interview, staff reported that the orientation processes prepares new staff well for their roles, but that additional time is often needed to ensure they can work independently in a competent manner.</p> <p>Continuing education is planned on an annual basis, including the mandatory training requirements, as listed in the policy and procedures developed with the quality/clinical consultant. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. A staff member is the internal assessor for the programme. Only two of the six registered nurses are maintaining their annual competency requirements to undertake interRAI assessments. The manager described the transient nature of registered nurses, most of who are immigrants, and noted that training all of these has not proven beneficial as they move on so quickly. Instead additional time is allocated for paperwork to the stable longer-term registered nurses. This system is working for the service provider. Current annual performance appraisals were found in all staff files reviewed and the manager confirmed these are currently up to date for all except two staff members who have been slow to complete their section.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate,</p>	<p>FA</p>	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility uses the interRAI acuity data report to guide staffing needs and staffing levels are adjusted accordingly to meet the changing needs of residents. Registered nurses may override this if the need arises such as for an outbreak. The facility manager is on call 24/7, although a registered nurse confirmed they relieve for on-call duties when the facility manager requests a break or has other</p>

<p>and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>commitments.</p> <p>During interview, care staff informed they have good access to advice when needed and they are well supported by registered nurses, the care coordinator and the facility manager. All reported there were adequate staff available to complete the work allocated to them, although this could depend on where they were working as workloads had become heavier. They informed an additional short shift that was trialled had been appreciated. Residents and family interviewed were full of praise for the staff. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. There is 24 hour/seven days a week registered nurse coverage in the hospital; however there have been intermittent occasions when there have not been sufficient registered nurses to cover all shifts as per contractual requirements. The section 31 notification process has been used to advise District Health Board and Ministry of Health officials. As all registered nurses have a current first aid certificate there is always at least one staff member who has a first aid certificate on duty, in addition to an enrolled nurse, the activity staff and the van drivers. Three of this team are scheduled to attend an update in November, which had been delayed because of Covid-19. In addition to meeting key requirements, a wound nurse is allocated to different wings as relevant and a mobility person works four hours three times a week.</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 is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed 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 as verified in staff files.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription and enters them into the system. All medications sighted were within current use by dates. Clinical pharmacist input is available on request.</p> <p>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.</p> <p>The records of temperatures for the medicine fridge and 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 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.</p> <p>There are three residents who self-administer medications (inhalers) at the time of audit. Appropriate processes are</p>

		<p>in place to ensure this is managed in a safe manner and the GP reviews this every three months. The medication is stored and recorded appropriately.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</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>	PA Low	<p>The food service is provided on site by a qualified chef, kitchen manager and kitchen team and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years (19 April 2019). Recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by Grey District Council current until 17 April 2021. Food temperatures, including for high risk items, are not being monitored appropriately and recorded as part of the plan which has resulted in a corrective action. The food services manager has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training as verified in staff files.</p> <p>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 are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals is verified by most resident and family interviews. A group of residents has recently met with the manager about the menu and this is being addressed. One of the residents who had expressed concern shared that she felt management had heard their concern and was confident of resolution. Residents observed during a meal time were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided in a respectful manner.</p>
<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>Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is appropriate. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs such as pressure relieving mattresses and cushions.</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>	<p>FA</p>	<p>The activities programme is provided by an activities coordinator who has begun her training in diversional therapy and a team of volunteers who take church services, housie and drive the van for outings.</p> <p>A social assessment and history are 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 after each activity recording residents' engagement and as part of the formal six monthly care plan review.</p> <p>Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings and satisfaction surveys. Residents interviewed confirmed they find the programme stimulating and enjoyable. On the day of audit a large group of residents was observed actively engaged in an activity.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. 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 urinary tract infections and wound management. When necessary, and for unresolved problems, long term care plans are added to and updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes. Multidisciplinary meetings are held six-monthly and family/whānau have opportunity for input.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>A building warrant of fitness on public display is dated 1 July 2020 and is valid for one year. No modifications have been made to the building since the last certification audit.</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>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, and the upper and lower respiratory tract. The IPC coordinator reviews all reported infections and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>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 are made. This information is reported to the quality committee. Data is benchmarked externally with other aged care providers through an online portal.</p> <p>There have been no outbreaks in the last year.</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 meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The care coordinator has the role of the restraint coordinator and works alongside the facility manager to provide support and oversight for enabler and restraint management in the facility. Both people demonstrated a sound understanding of the organisation's policies, procedures and practice and their roles and responsibilities in relation to restraint management.</p> <p>On the day of audit, the restraint register had three residents recorded as using a restraint. Two of these people have been using bedrails when on their beds since 2018 and one person uses a hip harness when in a pressure relieving flotation chair. There were no enablers in use at the time of audit. The facility manager informed a similar process is followed for the use of enablers as is used for restraints when they an enabler is requested.</p> <p>Staff confirmed during interview that restraint and enabler training is regularly offered (last recorded was dated July 2020) and a restraint competency is completed during orientation and annually thereafter. This was evident in a review of staff training records.</p>

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.1.1</p> <p>The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.</p>	PA Low	<p>There is a template for the development of a strategic/business plan within the service provider’s policy and procedure manuals; however this had not been used. The auditor was informed that there are several new board members, including a new chairperson, and the need for a strategic plan had been discussed. During the previous audit, a business plan, which had not been reviewed for that year had been provided; however the chairperson of the board at that time informed that nothing had changed and went through the plan with the auditor in detail to verify this. For this audit, not only was there not a current business plan, or similar document, that describes the current purpose, values, scope, direction and goals of the organisation but the copy of the previous version was not available. There was no official document to describe how any underlying goals are to be achieved.</p>	<p>There is not currently a business plan, or other current document, that describes the purpose, values, scope, direction and goals of the organisation as required by the standard.</p>	<p>Develop an up to date document that describes the purpose, values, scope, direction, and goals of the organisation with an outline of how the goals and objectives will be achieved.</p>



				180 days
<p>Criterion 1.3.13.5</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.</p>	PA Low	The kitchen has a current food safety plan but has not been monitoring temperatures of hot food as required in the food safety plan. Staff stated this was due to the purchase of a new thermometer that kitchen staff were unfamiliar with the use of and consequently over the last month have failed to record the required temperatures of food.	Temperatures of hot foods are not being measured in the kitchen to meet requirements of the food safety plan.	<p>Temperatures of hot food will be taken before meal service and recorded on the food safety plan daily diary.</p> <p>30 days</p>

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

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

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

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

No data to display
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End of the report.