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

Introduction

This report records the results of a Certification Audit; Partial Provisional Audit of a provider of aged residential care services against the Ngā paerewa Health and disability services standard (NZS8134:2021).

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 Manatū Hauora (the Ministry of Health).

The abbreviations used in this report are the same as those specified in section 0.4 of the Ngā paerewa Health and disability services standard (NZS8134:2021).

You can view a full copy of the standard on the Manatū Hauora 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: 8 October 2025 End date: 9 October 2025

Proposed changes to current services (if any): To convert 17 existing rest home beds to dual purpose hospital/rest home beds and to add one additional dual-purpose bed to give a maximum occupancy of 43.

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 sections contained within the Ngā paerewa Health and disability services standard:

- ō tātou motika │ our rights
- hunga mahi me te hanganga │ workforce and structure
- ngā huarahi ki te oranga │ pathways to wellbeing
- te aro ki te tangata me te taiao haumaru │ person-centred and safe environment
- te kaupare pokenga me te kaitiakitanga patu huakita │ infection prevention and antimicrobial stewardship
- here taratahi │ restraint and seclusion.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the subsection in each of the sections. 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 subsections applicable to this service fully attained with some subsections exceeded
	No short falls	Subsections 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 subsections applicable to this service partially attained and of low risk

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some subsections 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 subsections applicable to this service unattained and of moderate or high risk

General overview of the audit

Dixon House Rest Home (Dixon House) is owned and operated by the Dixon House Trust Board (Inc) and provides rest home and hospital level of care for up to 42 residents across 37 rooms. The service is managed by a general manager, who has been in the position since 2023, and a registered nurse, appointed as clinical nurse manager in January 2025. Dixon House has submitted a reconfiguration request to the Ministry of Health – HealthCERT requesting to convert 17 rest home beds to dual-purpose hospital or rest home level of care, and to convert a lounge area into a resident room with a dual-purpose bed to be used primarily for palliative care. Email confirmation was sighted to show these changes are supported by Health New Zealand -Te Whatu Ora (Te Whatu Ora).

This combined certification and partial provisional audit was conducted against Ngā Paerewa Health and Disability Standard NZS 8134:2021 to determine the service's level of compliance with the standard, and its preparedness and the suitability of the facility for the requested changes. The audit process included review of policies and procedures, review of resident's and staff files, observations, and interviews with residents, family members, the chair of the Dixon House Trust Board, managers, staff, and a general practitioner.

Areas requiring improvement were identified in relation to governance, organisational management, and the environment. Improvements are required to:

- The complaints process.

- Governance training in relation to Te Tiriti, health equity, and cultural safety.
- Implementation of the quality management system.
- Identification and management of risk.
- Registered nurse staffing levels required to provide clinically and culturally safe care.
- Police vetting of staff.
- Performance appraisals for caregivers.
- Review of the menu by a dietitian.
- Maintenance and upkeep of the environment, both internal and external.
- Provision of a safe and accessible outdoor area for residents' use.
- Confirmation of the appropriateness of the fire evacuation plan for a higher number of non-mobile residents from Fire and Emergency New Zealand (FENZ).
- Education of the infection prevention coordinator relevant to the role.

Ō tātou motika | Our rights

Includes 10 subsections that support an outcome where people receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of people's rights, facilitates informed choice, minimises harm, and upholds cultural and individual values and beliefs.		Some subsections applicable to this service partially attained and of low risk.

Dixon House works collaboratively to support and encourage a Māori world view of health in service delivery. There were no residents who identified as Māori at the time of audit. However, policies and procedures were in place to ensure Māori would be provided with equitable and effective services based on Te Tiriti o Waitangi and the principles of mana motuhake when admitted.

There were no residents from Pacific communities; however, Dixon House had policies and procedures in place to ensure Pacific peoples would be provided with services that recognise their worldviews in a culturally safe manner.

Residents and their whānau were informed of their rights according to the Code of Health and Disability Services Consumers' Rights (the Code), and these were upheld. Personal identity, independence, privacy and dignity were respected and supported. Staff had participated in Te Tiriti o Waitangi training, which was reflected in day-to-day service delivery. Residents were safe from abuse.

Residents and whānau received information in an easy-to-understand format and felt listened to and included when making decisions about care and treatment. Open communication was practised. Interpreter services were provided as needed. Whānau and legal representatives were involved in decision-making that complied with the law. Advance directives were followed wherever possible.

Interviews confirmed that residents and whānau were satisfied with how complaints were managed.

Hunga mahi me te hanganga | Workforce and structure

Includes five subsections that support an outcome where people receive quality services through effective governance and a supported workforce.		Some subsections applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

Dixon House Trust Board (Inc), as the governing body, assumes accountability for delivering a high-quality service. This includes supporting meaningful inclusion of Māori in governance groups, honouring Te Tiriti, and reducing barriers to improve outcomes for Māori and people with disabilities (tāngata whaikaha).

Planning ensures the purpose, values, direction, scope and goals for the organisation are defined. Organisational performance is monitored and reviewed at planned intervals.

Dixon House aims to have quality and risk management systems that are focused on improving service delivery and care using a risk-based approach. Residents and whānau provided regular feedback, and staff were involved in quality activities. An integrated approach included collection and analysis of quality improvement data. A risk register was in place, with mitigation strategies documented for identified risks.

The National Adverse Events Policy is followed. The service has complied with statutory and regulatory reporting obligations.

Staffing levels and skill mix aim to meet the cultural and clinical needs of residents. Human resource policies were in place and were based on current good practice. A systematic approach to identify and deliver ongoing learning supports safe equitable service delivery.

Residents' information was accurately recorded, securely stored, and not accessible to unauthorised people.

Ngā huarahi ki te oranga | Pathways to wellbeing

Includes eight subsections that support an outcome where people participate in the development of their pathway to wellbeing, and receive timely assessment, followed by services that are planned, coordinated, and delivered in a manner that is tailored to their needs.		Some subsections applicable to this service partially attained and of low risk.

When residents enter Dixon House, a person-centred and whānau-centred approach has been adopted. Relevant information about the service was provided to the potential resident and their whānau to support informed decision-making and a smooth transition into care.

The service worked in partnership with residents and their whānau to assess, plan, and evaluate care. Each care plan was individualised, based on comprehensive assessment information, and updated to reflect any new needs or changes in health status. Files reviewed demonstrated that care had been delivered in a way that meets the needs, preferences, and goals of residents and their whānau, and that these plans were regularly and appropriately evaluated and updated as needed.

Residents were supported to maintain and develop their interests, abilities, and connections, and to participate in meaningful activities within the home and wider community that were suitable to their age and stage of life.

Medicines were safely managed and administered by competent, authorised staff, following current best-practice and organisational policies.

The food service at Dixon House met the nutritional needs and preferences of residents. Cultural, medical, and personal dietary requirements were accommodated. Food was prepared and served safely in line with food safety standards.

Residents were referred or transferred to other health and support services as required, to ensure continuity and quality of care.

Te aro ki te tangata me te taiao haumaru | Person-centred and safe environment

Includes two subsections that support an outcome where Health and disability services are provided in a safe environment appropriate to the age and needs of the people receiving services that facilitates independence and meets the needs of people with disabilities.		Some subsections applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

The facility was clean, with spacious rooms. There was a current building warrant of fitness. Electrical and biomedical testing of equipment occurs as required.

Staff had been trained in emergency procedures, the use of emergency equipment and supplies, and attended regular fire drills. Staff, residents and whānau understood emergency and security arrangements. Residents interviewed reported a timely staff response to call bells. Security was maintained.

Te kaupare pokenga me te kaitiakitanga patu huakita | Infection prevention and antimicrobial stewardship

Includes five subsections that support an outcome where Health and disability service providers' infection prevention (IP) and antimicrobial stewardship (AMS) strategies define a clear vision and purpose, with quality of care, welfare, and safety at the centre. The IP and AMS programmes are up to date and informed by evidence and are an expression of a strategy that seeks to maximise quality of care and minimise infection risk and adverse effects from antibiotic use, such as antimicrobial resistance.		Some subsections applicable to this service partially attained and of low risk.

Infection prevention (IP) and antimicrobial stewardship (AMS) programmes were in place to ensure the safety of residents and staff. These programmes were appropriate to the size and complexity of the service and were led by an experienced infection prevention and control coordinator.

The infection control coordinator is actively involved in procurement processes, facility changes, and all processes related to the decontamination of reusable medical devices.

Staff demonstrated sound knowledge and practice around infection prevention and control. Staff, residents, and whānau were familiar with the service's pandemic and infectious diseases response plan.

The service promotes the responsible prescribing and use of antimicrobials. Infection surveillance had been undertaken regularly, with appropriate follow-up actions taken where required.

The physical environment supports infection prevention and minimises the risk of transmission. Waste and hazardous substances were well managed, and laundry services were provided in a safe and effective manner.

Here taratahi | Restraint and seclusion

Includes four subsections that support outcomes where Services shall aim for a restraint and seclusion free environment, in which people's dignity and mana are maintained.		Subsections applicable to this service fully attained.

Dixon House is a restraint-free environment. This is supported by the governing body and policies and procedures. There were no residents observed to be using restraints at the time of audit.

A comprehensive assessment, approval and monitoring process, with regular reviews, was in place should restraint be required in the future. All restraint is reported to the governing body.

Policy requires that restraint education/training is included at orientation and then annually. Competencies are assessed. Staff demonstrated a sound knowledge and understanding of providing the least restrictive practice, de-escalation techniques, and alternative interventions.

Summary of attainment

The following table summarises the number of subsections 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)
Subsection	0	18	0	6	3	0	0
Criteria	0	156	0	8	4	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)
Subsection	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Ngā paerewa Health and disability services standard

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

For more information on the standard, please click here.

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

Subsection with desired outcome	Attainment Rating	Audit Evidence
Subsection 1.1: Pae ora healthy futures Te Tiriti: Māori flourish and thrive in an environment that enables good health and wellbeing. As service providers: We work collaboratively to embrace, support, and encourage a Māori worldview of health and provide high-quality, equitable, and effective services for Māori framed by Te Tiriti o Waitangi.	FA	Dixon House had developed policies, procedures and processes to embed and enact Te Tiriti o Waitangi in all aspects of its work. Mana motuhake (self-determination) was understood and respected. Partnerships have been established with two Kaiwhakahaere / Māori wardens to support service integration, planning, equity approaches and support for Māori. A Māori health plan has been developed with input from cultural advisers, and this was available to be used for residents who identify as Māori. There were no residents who identified as Māori at the time of audit. Staff interviewed gave examples of how they had respected the rights of Māori to self-determination and provided culturally safe care in the past. Strategies to actively recruit and retain a Māori health workforce across roles were discussed. At the time of audit there were staff employed who identified as Māori; they are available to support residents and staff guiding them in Tikanga Māori practices as needed. Staff ethnicity data is documented on recruitment and trended.

Subsection 1.2: Ola manuia of Pacific peoples in Aotearoa The people: Pacific peoples in Aotearoa are entitled to live and enjoy good health and wellbeing. Te Tiriti: Pacific peoples acknowledge the mana whenua of Aotearoa as tuakana and commit to supporting them to achieve tino rangatiratanga. As service providers: We provide comprehensive and equitable health and disability services underpinned by Pacific worldviews and developed in collaboration with Pacific peoples for improved health outcomes.	FA	The Pacific peoples' community in Te Tai o Poutini (West Coast) is small, and there were no residents who identified as being from a Pacific community at the time of audit. Policies and procedures were in place to ensure Dixon House could work in partnership with Pacific communities and organisations to provide a Pacific plan supporting culturally safe practices for Pacific peoples using the service, and on achieving equity. Partnerships enabled ongoing planning and evaluation of services and outcomes. Staff had access to the Fonofale model of care to use with Pacific residents when needed, ensuring their worldview, and cultural and spiritual beliefs would be embraced. Active recruitment, training, and actions to retain a Pacific workforce are supported at Dixon House and this was described in policy, resulting in staff from Pacific communities being employed across roles.
Subsection 1.3: My rights during service delivery The People: My rights have meaningful effect through the actions and behaviours of others. Te Tiriti:Service providers recognise Māori mana motuhake (self-determination). As service providers: We provide services and support to people in a way that upholds their rights and complies with legal requirements.	FA	Staff at Dixon House demonstrated a clear understanding of the requirements of the Code and were observed supporting residents in ways that reflected their individual preferences, choices, and mana motuhake. Residents and whānau interviewed at Dixon House reported being informed about the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) and said they had opportunities to discuss and clarify their rights. The Code was displayed in both te reo Māori and English in the reception and resident areas. Residents and whānau showed a good understanding of their rights and expressed confidence that Dixon House staff consistently respect and uphold these rights, ensuring that the principles of dignity, respect, and mana motuhake are observed in all aspects of care and daily interaction.

Subsection 1.4: I am treated with respect The People: I can be who I am when I am treated with dignity and respect. Te Tiriti: Service providers commit to Māori mana motuhake. As service providers: We provide services and support to people in a way that is inclusive and respects their identity and their experiences.	FA	The services at Dixon House supported residents in a way that was inclusive and respectful of their individual identity, background, and life experiences. Residents and whānau, including those with disabilities, confirmed that services were being delivered in a manner that upheld their dignity, gender, privacy, sexual orientation, spirituality, and personal choices. During the audit, staff were observed maintaining residents' privacy. Residents at Dixon House have their own private room or share a room with another person only with their consent. Te reo Māori and tikanga Māori are actively promoted within Dixon House through Māori language sessions, cultural celebrations, and engagement in local community events. Staff have completed training in Te Tiriti o Waitangi and demonstrated understanding of its principles, applying them in their everyday practice. The needs of tāngata whaikaha were acknowledged and supported, including opportunities for participation in te ao Māori. Residents shared examples showing that their individual preferences and cultural choices are recognised and consistently respected by staff, reflecting the home's strong commitment to inclusivity, dignity, and mana motuhake.
Subsection 1.5: I am protected from abuse The People: I feel safe and protected from abuse. Te Tiriti: Service providers provide culturally and clinically safe services for Māori, so they feel safe and are protected from abuse. As service providers: We ensure the people using our services are safe and protected from abuse.	FA	Employment policies at Dixon House required the police vetting of all staff. However, evidence was not available to confirm this had happened consistently; refer criterion 2.4.1. Staff at Dixon House demonstrated a clear understanding of the service's policy on abuse and neglect, including recognising early signs and knowing the appropriate steps to take if concerns arise. Education on abuse and neglect had been provided to all staff, ensuring they were confident in the prevention, identification, and reporting processes. There were no examples of discrimination, coercion, or harassment identified during the audit through staff, resident, or whānau interviews, observations, or in the documentation reviewed. Residents' property was observed to be labelled on admission, and residents confirmed their belongings treated with respect and care.

		Policy was in place to protect resident finances, and staff do not handle residents' money. Professional boundaries were maintained by staff. Staff interviewed reported that they feel comfortable raising any concerns related to institutional or systemic racism and believe these would be taken seriously and appropriately addressed. A strengths-based and holistic model of care was evident throughout Dixon House, observed in interactions between staff and residents and reflecting principles of Te Whare Tapa Whā and other culturally responsive frameworks that support residents' overall wellbeing, dignity, and safety.
Subsection 1.6: Effective communication occurs The people: I feel listened to and that what I say is valued, and I feel that all information exchanged contributes to enhancing my wellbeing. Te Tiriti: Services are easy to access and navigate and give clear and relevant health messages to Māori. As service providers: We listen and respect the voices of the people who use our services and effectively communicate with them about their choices.	FA	Residents and whānau at Dixon House reported that communication is open, respectful, and effective, and they feel listened to and well informed. Information had been provided in clear, easy-to-understand formats, and any changes to residents' health status were communicated to whānau promptly. When other agencies were involved in a resident's care, communication between parties was well-coordinated. Staff understood the principles of open disclosure, which is supported by policies and procedures. Examples of open and transparent communication were evident following adverse events. Staff were observed throughout the day engaging in regular, supportive communication with residents, whānau, and colleagues. A variety of communication methods were available to meet residents' individual needs, including written information, visual aids, and verbal discussions. Interpreter services are accessible when required, and cultural advisors are available to support communication with residents and whānau, ensuring inclusive and culturally appropriate interactions.
Subsection 1.7: I am informed and able to make choices The people: I know I will be asked for my views. My choices will be	FA	Residents and their legal representatives at Dixon House were provided with clear information to support informed decision-making.

respected when making decisions about my wellbeing. If my choices cannot be upheld, I will be provided with information that supports me to understand why. Te Tiriti: High-quality services are provided that are easy to access and navigate. Providers give clear and relevant messages so that individuals and whānau can effectively manage their own health, keep well, and live well. As service providers: We provide people using our services or their legal representatives with the information necessary to make informed decisions in accordance with their rights and their ability to exercise independence, choice, and control.		Residents and whānau reported feeling empowered to actively participate in decisions about care and daily living. With the residents' consent, whānau were included in discussions and decisions relating to their care. Nursing and care staff interviewed demonstrated a sound understanding of the principles and practice of informed consent, supported by policies that align with the Code and incorporate tikanga guidelines. Residents and whānau interviewed described being asked for their individual preferences and stated that they were supported to make choices about their care, routines, and lifestyle. Advance care planning, establishing and documenting of enduring power of attorney (EPOA) requirements and processes for residents unable to consent were documented, as relevant, in the resident's record. Advance care planning was evident, including discussions on shared goals of care. Processes and policies for obtaining informed consent were in place, with examples sighted during the audit.
Subsection 1.8: I have the right to complain The people: I feel it is easy to make a complaint. When I complain I am taken seriously and receive a timely response. Te Tiriti: Māori and whānau are at the centre of the health and disability system, as active partners in improving the system and their care and support. As service providers: We have a fair, transparent, and equitable system in place to easily receive and resolve or escalate complaints in a manner that leads to quality improvement.	PA Low	Policy described a fair, transparent, and equitable system to receive and resolve complaints that leads to improvements. The process described the required documentation and timeframes for acknowledgment, investigation and response to complainants, which meets the requirements of the Code. Residents and whānau interviewed understood their right to make a complaint and knew how to do so. Complaint forms are made available in the resident welcome pack and at the entry to the facility. The general manager (GM) is responsible for implementing the complaints policy, including acknowledgement, investigation and response to complainants. When interviewed, they described acknowledging and responding to complainants verbally. However, not all aspects of complaint management were documented, and evidence to confirm that complaints had been acknowledged and responded to in the required timeframe was not available; refer criterion 1.8.3. Documentation was not available to confirm complainants had been informed of findings of their complaint

		following investigation; refer criterion 1.8.4. Improvements identified from complaints investigations and internal audits of the complaints process did not always result in corrective action planning; refer criterion 2.2.2. Staff interviewed were aware of what to do should a resident or whānau member complain. The service assures the process works equitably for Māori by meeting with complainants, offering the support of Māori wardens who work with the facility, and the use of interpreters. Four complaints had been received since the last audit. These related to call bell response times, resident behaviours and care provision. Te Whatu Ora reported that one complaint had been received regarding care at Dixon House since the last audit; this was unsubstantiated, and no other no complaints had been received from external sources since the previous audit.
Subsection 2.1: Governance The people: I trust the people governing the service to have the knowledge, integrity, and ability to empower the communities they serve. Te Tiriti: Honouring Te Tiriti, Māori participate in governance in partnership, experiencing meaningful inclusion on all governance bodies and having substantive input into organisational operational policies. As service providers: Our governance body is accountable for delivering a highquality service that is responsive, inclusive, and sensitive to the cultural diversity of communities we serve.	PA Low	The Dixon House Trust Board (Inc), as the governing body, assumes accountability for delivering a high-quality service to the residents at Dixon House. There is meaningful inclusion of Māori on governance groups, and external advice from local Māori was available. The board chair was interviewed and was unable to confirm that members of the board had completed training or demonstrated expertise in Te Tiriti o Waitangi, health equity, and cultural safety; refer criterion 2.1.10. The board chair was aware of the need to focus on improving outcomes for Māori, Pacific peoples, and tāngata whaikaha. However, they stated that currently, the main focus of the board was on the financial sustainability of the service. Dixon House is managed by a GM who previously worked as the administrator at Dixon House and has been in the manager position since 2023. They have recently completed a Diploma in Business Management Level 5 and was suitably qualified for the role. The GM is supported by a clinical nurse manager (CNM) who has been in the position since January 2025. An enrolled nurse (EN) who previously worked as the clinical manager until the last audit continues to support the GM in a care coordination role, which is

		primarily office based. Further support to the GM and board is provided by an external clinical and compliance advisor who specialises in aged-care governance and management. The leadership structure, including for clinical governance was appropriate to the size and complexity of the organisation. Compliance with legislative, contractual, and regulatory requirements is overseen by the GM and the board, with support from the external clinical and compliance advisor. Any changes are translated into policy and procedures, which were current, having been reviewed in July 2025. The purpose, values, direction, scope and goals of the organisation were defined in a business plan. The plan had remained in draft until finalised and approved by the board chair on the day of audit. Monitoring and reviewing of performance occurred through monthly board reports. This includes the board receiving regular information from the service to show progress towards goals and monitoring of key performance indicators (KPI). Internal data had been collected (e.g., adverse events, infections, and complaints) and reported to the board; this was confirmed in a sample of reports to the board. The board chair interviewed felt well informed on progress and risks. However, not all risks were documented; refer criterion 2.2.4. A focus on identifying barriers to access, improving outcomes, and achieving equity for Māori and tāngata whaikaha was evident in the business plan and monitoring documentation reviewed, and through interviews. A commitment to the quality and risk management system was evident. However, not all elements of the quality system had been implemented; refer criterion 2.2.2. Residents and whānau participated in the planning and evaluation of services through surveys, resident meetings, and evaluation of care plans. Dixon House holds contracts with Te Whatu Ora to provide age-related residential care at rest home and hospital level, including respite and end-of-life care. The service also holds contracts with the Ministry of Social Development, Disability Support Services (DSS) for the care of younger people with a disability, and with the Accident Compensation Corporation (ACC). At the time of audit, 37 residents were receiving care including one couple in a double

		occupancy room; 17 at hospital level and 20 at rest home level including one under a DSS contract. No residents were receiving care under the respite, end-of-life or ACC contracts. Partial Provisional Audit. The board chair is supportive of the proposed changes, which will increase the financial viability of the service. The governance and leadership structure in place, together with support from external advisors, is appropriate for the changes proposed.
Subsection 2.2: Quality and risk The people: I trust there are systems in place that keep me safe, are responsive, and are focused on improving my experience and outcomes of care. Te Tiriti: Service providers allocate appropriate resources to specifically address continuous quality improvement with a focus on achieving Māori health equity. As service providers: We have effective and organisation-wide governance systems in place relating to continuous quality improvement that take a risk-based approach, and these systems meet the needs of people using the services and our health care and support workers.	PA Moderate	Dixon House had a documented quality and risk system that reflected the principles of continuous quality improvement. This included the management of incidents and complaints, internal audit activities, a regular resident and whānau satisfaction survey, monitoring of outcomes, policies and procedures, and clinical incidents including infections, and adverse events. However, not all elements of the quality and risk system had been fully implemented; refer criterion 2.2.2. Residents, whānau and staff contributed to quality improvement through annual surveys, meetings, and adverse event follow up. The most recent resident satisfaction survey was conducted in August 2025 and showed positive results related to care provision and the responsiveness of staff. Negative comments related to the food service. However, no corrective action follow-up had occurred; refer criterion 2.2.2. The GM reported that they do not conduct a staff survey; staff are welcome to give feedback at the staff meeting. However, meeting minutes were not sufficiently detailed to document what had occurred or was discussed, did not document decisions made or actions to be taken, or identify the person responsible for follow-up actions. Staff reported that there was no follow-up to issues raised; refer criterion 2.2.2. Critical analysis of practices and systems, using ethnicity data, identifies possible inequities and the service works to address

		these. Reports were sighted to confirm that analysis had occurred, analysis included ethnicity data and that progress against quality outcomes was monitored. However, no evidence of corrective action or quality improvement plans being put in place was available; refer criterion 2.2.2. Delivering high-quality care to Māori residents had been supported through relevant training, tikanga policies, and access to cultural support roles internally and externally. The service is supported by two Māori wardens, and a Māori health plan guides care for Māori. Policies reviewed covered all necessary aspects of the service and of contractual requirements and were current, having been reviewed by the clinical and compliance advisor in July 2025. The GM described the processes for the identification, documentation, monitoring, review and reporting of risks, including health and safety risks, and development of mitigation strategies. Staff knew to report risks. However, not all risks identified were included on the risk register and risks rated as high are not always reported to or reviewed by the board; refer criterion 2.2.4. Staff documented adverse and near miss-events in line with the National Adverse Events Policy. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, and care planning was updated as needed. However, action plans were not always developed to improve service delivery; refer criterion 2.2.2. The enrolled nurse care coordinator (ENCC) understood and had complied with essential notification reporting requirements. Interview with the GM, ENCC and CNM confirmed this was not the responsibility of the CNM at Dixon House. A Section 31 notification sent to HealthCERT for the change of clinical manager (6 January 2025) was sighted. Notification of the change of board members (two) occurred on the day of audit. Individual cases of COVID-19 infection were reported via Section 31 notifications; multiple examples were sighted. No reporting to the Health Quality & Safety Commission for pressure injuries or clinical incidents had been required. There had been no police or coronial investigations since the last

		audit.
Subsection 2.3: Service management The people: Skilled, caring health care and support workers listen to me, provide personalised care, and treat me as a whole person. Te Tiriti: The delivery of high-quality health care that is culturally responsive to the needs and aspirations of Māori is achieved through the use of health equity and quality improvement tools. As service providers: We ensure our day-to-day operation is managed to deliver effective person-centred and whānau-centred services.	PA Moderate	There was a documented process for determining staffing levels and skill mixes. The facility uses a staffing formula worksheet developed by the external clinical and compliance advisor to determine the daily and weekly hours for RNs and caregivers to provide culturally and clinically safe care, 24 hours a day, seven days a week (24/7). The formula adjusts staffing levels to meet the changing needs of residents. Six weeks of rosters reviewed showed that caregiver levels were in line with identified hours required. However, RN hours were not; refer criterion 2.3.1. A multidisciplinary team (MDT) approach was in place to meet service delivery needs. Caregivers reported there were adequate staff to complete the work allocated to them. Residents and whānau interviewed supported this. At least one staff member on duty had a current first aid certificate and there is 24/7 RN coverage, as confirmed in the rosters reviewed. The employment process, which included a job description defining the skills, qualifications and attributes for each role, ensured services were delivered to meet the needs of residents. Continuing education was planned on an annual basis, including mandatory training requirements. Related competencies were assessed and supported equitable service delivery and the ability to maximise the participation of residents using the service and their whānau. High-quality Māori health information was accessed through contacts with the local marae and used to support training and development programmes, policy development, and care delivery. Caregivers have access to the New Zealand Qualifications Authority education programme to meet the requirements of the provider's agreement with Te Whatu Ora. Records reviewed demonstrated completion of the required training and competency assessments. The GM confirmed a staff survey is not conducted, and the service

		does not subscribe to an employee assistance programme. The GM has an open-door policy, and staff can raise concerns at meetings. However, these were not well documented; refer criterion 2.2.2. Staff reported that support was available, they felt safe in the workplace, and it was a positive work environment. Partial Provisional Audit The systems and process in place will be appropriate for the proposed changes once the deficits identified under criterion 2.3.1 are corrected. There was a documented plan using the staffing formula worksheet that identified the staffing implications of increasing the number of hospital-level residents. This identified that an increase in both caregiver and RN hours would be needed. At the time of audit, recruitment had not begun and funding for increased staffing levels had not been approved by the board; refer criterion 2.3.1.
Subsection 2.4: Health care and support workers The people: People providing my support have knowledge, skills, values, and attitudes that align with my needs. A diverse mix of people in adequate numbers meet my needs. Te Tiriti: Service providers actively recruit and retain a Māori health workforce and invest in building and maintaining their capacity and capability to deliver health care that meets the needs of Māori. As service providers: We have sufficient health care and support workers who are skilled and qualified to provide clinically and culturally safe, respectful, quality care and services.	PA Low	Human resources management policies and processes, developed by an external contractor, are based on good employment practice and relevant legislation. A sample of ten staff records reviewed confirmed the organisation's policies are being consistently implemented, except for police vetting; refer criterion 2.4.1. Job descriptions were documented for each role. Professional qualifications and registration (where applicable) had been validated prior to employment and annual practising certificates for employed and contracted health professionals were validated annually thereafter; this was confirmed in records sighted. The roles and responsibilities for staff with specific functions, such as restraint coordinator (RC) or infection prevention and control coordinator (IPCC), were included in policy and known to the staff concerned. Staff reported that the induction and orientation programme prepared them well for their role, and evidence of this was seen in files reviewed. Policy described opportunities to discuss and review performance following orientation and yearly thereafter. Review of RN and EN records confirmed this was occurring for nursing staff.

		However, while caregivers had a completed performance appraisal on file, interview with the GM, ENCC and caregivers confirmed they complete a self-assessment and they did not always have the opportunity to discuss and review their performance; refer criterion 2.4.5. Staff information, including ethnicity data, was accurately recorded, held confidentially, and used in line with the Health Information Standards Organisation (HISO) requirements. There were staff wellbeing policies, and staff were aware of these. Staff interviewed confirmed that debrief and support was available to them following any serious incidents or challenging situations. Partial Provisional Audit The systems and processes in place will be appropriate for the proposed changes once the deficits identified under criteria 2.4.1 and 2.4.5 are corrected.
Subsection 2.5: Information The people: Service providers manage my information sensitively and in accordance with my wishes. Te Tiriti: Service providers collect, store, and use quality ethnicity data in order to achieve Māori health equity. As service provider: We ensure the collection, storage, and use of personal and health information of people using our services is accurate, sufficient, secure, accessible, and confidential.	FA	Dixon House maintained resident records that complied with relevant legislation, health information standards, and professional guidelines using an electronic system. All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current, integrated and legible, and met current documentation standards. Electronic information was username- and password-protected, and accessible only to those who need it. Any paper-based records are held securely for the required period before being destroyed. No personal or private resident information was on public display during the audit. Dixon House is not responsible for National Health Index (NHI) registration.
Subsection 3.1: Entry and declining entry The people: Service providers clearly communicate access,	FA	At Dixon House, residents enter the service once their required level of care has been assessed and confirmed by the local Needs

timeframes, and costs of accessing services, so that I can choose the most appropriate service provider to meet my needs. Te Tiriti: Service providers work proactively to eliminate inequities between Māori and non-Māori by ensuring fair access to quality care. As service providers: When people enter our service, we adopt a person-centred and whānau-centred approach to their care. We focus on their needs and goals and encourage input from whānau. Where we are unable to meet these needs, adequate information about the reasons for this decision is documented and communicated to the person and whānau.		Assessment and Service Coordination (NASC) agency. Files reviewed met contractual requirements. Entry is based on documented criteria that are available to the community and understood by staff, and the process meets the needs of residents. Whānau interviewed were satisfied with the admission process and the information provided. Prior to admission, an admission pack is provided to residents and their whānau, outlining the service, residents' rights, and what to expect. On admission, consent forms and admission agreements are completed, and copies are retained in residents' files. Where there was a delay in admission there was ongoing communication with the potential resident and whānau. Review of documentation confirmed these requirements were met. Where a prospective resident is declined entry, the decision is communicated clearly and respectfully. Related data, including entry and decline rates for Māori, is documented and analysed to support equitable access. Mana motuhake is respected at Dixon House. Partnerships have been established with two kaiwhakahaere / Māori wardens who work alongside the service to support Māori and their whānau when entering the service. Collaboration with Māori cultural advisers, the resident GP, and traditional health practitioners ensures culturally responsive care pathways are available for Māori residents and their whānau. A Māori health plan has been developed with input from these cultural partners and is available to guide care for residents who identify as Māori.
Subsection 3.2: My pathway to wellbeing The people: I work together with my service providers so they know what matters to me, and we can decide what best supports my wellbeing. Te Tiriti: Service providers work in partnership with Māori and whānau, and support their aspirations, mana motuhake, and whānau rangatiratanga. As service providers: We work in partnership with people and	FA	At Dixon House, the multidisciplinary team worked in partnership with residents and their whānau to support overall wellbeing. Each care plan had been developed by qualified staff following a comprehensive assessment that considered the person's lived experience, cultural needs, values, and beliefs, and integrated wider service support where required. Early warning signs and potential risks were identified, with a focus on prevention and timely intervention.

whānau to support wellbeing.		Care plans audited on the day showed that goals, interventions, and evaluations were well documented. Plans were individualised and included diversional therapy components, as well as spiritual and cultural needs. Examples were provided showing how cultural care plans were completed in alignment with the Fonofale and Te Whare Tapa Whā models of care for Māori residents in the past. Care plans were updated as residents' needs changed, with evidence of timely reviews and responsive documentation. Short-term care plans were used effectively to manage temporary or acute issues—such as infections, wound care, or changes in mobility—and these were transferred to the long-term care plan when ongoing support was required. Wound care plans were in place and regularly evaluated to ensure progress and healing outcomes were achieved. While there were no Māori or Pacific residents in the facility at the time of audit, processes were in place to ensure cultural assessments could be completed by culturally competent staff when required. This included access to traditional healing practitioners, rākau rongoā, mirimiri, and karakia when requested or appropriate. Assessments were completed electronically through the resident management system (RMS), incorporating interRAI scoring and other clinical assessment tools. All required interRAI assessments were up to date. Timeframes for assessments, initial and long-term care plans, and reviews met policy and contractual requirements. Staff demonstrated an understanding of supporting Māori and their whānau to identify their own pae ora outcomes within care planning. This was verified through record sampling and interviews with staff, residents, and whānau. Whānau were actively involved in care planning and review processes, contributing to shared decision-making and providing feedback to ensure care remained relevant and responsive to each resident's needs. Feedback from whānau was also sought through meetings, surveys, and informal discussions, and this feedback was used to guide service improvements. Management of specific medical conditions was clearly documented, with evidence of systematic monitoring, evaluation, and timely updates to care plans in collaboration with residents and

		whānau. Residents and whānau confirmed they were actively involved in all aspects of care planning. The General Practitioner (GP) interviewed stated they were very satisfied with the standard of care provided at Dixon House, noting that referrals to their service were appropriate and timely. The GP commended the clinical competence, communication, and professionalism of the clinical staff. Ngā tāngata whaikaha participated in service development through regular feedback, resident meetings, and one-on-one diversional therapy sessions. Residents and whānau described having choice and control over their care, and information was readily accessible to them.
Subsection 3.3: Individualised activities The people: I participate in what matters to me in a way that I like. Te Tiriti: Service providers support Māori community initiatives and activities that promote whanaungatanga. As service providers: We support the people using our services to maintain and develop their interests and participate in meaningful community and social activities, planned and unplanned, which are suitable for their age and stage and are satisfying to them.	FA	The activities programme at Dixon House supported residents to maintain and develop their interests and was suitable for their age and stage of life. The diversional and recreational therapy programme was led by a qualified diversional therapist (DT) who had worked at Dixon House for many years, progressing through a range of roles within the facility. The DTs extensive experience provided a deep understanding of residents' needs and preferences. The DT personalised the activities programme to align with each resident's individual goals and abilities. The programme was culturally responsive and included cultural-specific activities such as Māori language sessions with staff, whānau, and residents, as well as Pacific-themed events and cultural celebration days. While there were no Māori residents in the facility at the time of audit, opportunities can be facilitated for Māori and their whānau to participate in te ao Māori and related activities when appropriate. Te reo Māori was incorporated into care planning, and community initiatives were inclusive, reflecting the cultural diversity of residents. Diversional therapy care plans had been updated regularly, with goals, interventions, and evaluations reviewed at defined intervals. The monthly activity plan included a variety of stimulating and engaging options such as community outings, visits to local cafés and libraries, gardening, cooking sessions, spiritual and religious

		services (including weekly church services), and quieter one-on-one sessions for residents who preferred a more relaxed pace. On the day of audit, residents were observed enthusiastically participating in a housie game and a themed dress-up event in 1950s attire. The facility was also preparing for its upcoming mini Olympic Games and a planned trip to an American diner. Residents and whānau were extremely complimentary about the activities programme, describing it as inclusive, enjoyable, and responsive to individual preferences. Feedback was gathered through resident meetings, informal discussions, and whānau engagement, ensuring the programme continued to evolve in line with residents' needs and interests.
Subsection 3.4: My medication The people: I receive my medication and blood products in a safe and timely manner. Te Tiriti: Service providers shall support and advocate for Māori to access appropriate medication and blood products. As service providers: We ensure people receive their medication and blood products in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	The medication management policy at Dixon House was current and aligned with the Medicines Care Guide for Residential Aged Care and current best practice. A safe and effective electronic medication management system was in place and observed to be functioning well on the day of audit. An RN was observed administering medications in a safe, competent, and professional manner, following correct procedures and maintaining residents' privacy and dignity throughout. Medication reconciliation occurred as required, and all medicines sighted were within current use-by dates. Prescribing practices met requirements, with medicine-related allergies and sensitivities clearly recorded and any adverse reactions managed appropriately. Over-the-counter medicines and supplements had been reviewed and authorised by the prescriber as part of each resident's medication profile. Medicines were securely stored, including controlled drugs, with stock checks completed as required and storage temperatures maintained within recommended ranges. The controlled drug register had been properly completed, with weekly, monthly, and six-monthly checks and reconciliations carried out, including verification by the supplying pharmacy. Standing orders were not

		used at Dixon House. Weekly medication chart audits were completed by staff to ensure accuracy and compliance, and any discontinued or expired medications were promptly returned to the pharmacy for safe disposal. The required three-monthly General Practitioner (GP) reviews were consistently recorded on medication charts, and prescribing practices reflected a strong focus on antimicrobial stewardship and reducing polypharmacy. Residents were supported to understand their medications, and education had been provided to residents and whānau when medication changes occurred. One resident self-administered their own medicines; this was facilitated safely. A full competency assessment had been completed and reviewed in line with policy requirements, including the six-monthly re-evaluation of self-medication competence. Partial Provisional The current medication management system and pharmacy arrangements are appropriate to support the safe management and administration of medicines for additional hospital-level care residents. Processes can be readily scaled to meet the increased clinical complexity associated with higher acuity care.
Subsection 3.5: Nutrition to support wellbeing The people: Service providers meet my nutritional needs and consider my food preferences. Te Tiriti: Menu development respects and supports cultural beliefs, values, and protocols around food and access to traditional foods. As service providers: We ensure people's nutrition and hydration needs are met to promote and maintain their health and wellbeing.	PA Low	The food services at Dixon House were in line with recognised best practice nutritional standards and guidelines for residents using the service. While a nutritious and well-balanced menu was sighted, there was no evidence that a qualified dietitian had reviewed the current menu within the last two years; refer criterion 3.5.4. All aspects of food management complied with current legislation and guidelines. The service operated under an approved food control plan and registration, and safe food-handling practices were observed. Each resident had a nutritional assessment completed on admission, and these were all up to date at the time of audit. Personal food preferences, special diets, allergies, and modified

		texture requirements were accommodated in the daily meal plan. The cook demonstrated sound knowledge of each resident's dietary needs and preferences, including medical and cultural requirements. Snacks and additional food were always readily available for residents requiring extra nourishment. Residents and whānau had opportunities to be involved in food preparation and menu planning as appropriate to the service, including participating in baking, meal preparation, and cultural celebration events as part of the activities programme. Although there were no Māori residents at the time of audit, the facility was able to cater for culturally specific food preferences and provide menu options reflective of te ao Māori. This was demonstrated through examples of how staff had supported other residents with cultural dietary needs. Nutritional supplements were prescribed by the GP and prepared by RNs. Residents observed during mealtimes appeared relaxed and content, stating they were happy with both the quality and variety of food offered. Meals were served in an unhurried and respectful manner, with assistance provided as needed in a way that upheld residents' dignity. Resident and whānau feedback, satisfaction surveys, and meeting minutes confirmed a high level of satisfaction with the food service. Partial Provisional The current kitchen and food service facilities are adequate to support additional hospital-level care residents. Menu and meal delivery processes can be adapted as required to meet the nutritional and clinical needs of residents with higher acuity.
Subsection 3.6: Transition, transfer, and discharge The people: I work together with my service provider so they know what matters to me, and we can decide what best supports my wellbeing when I leave the service. Te Tiriti: Service providers advocate for Māori to ensure they and	FA	Transfer or discharge from Dixon House was planned and managed safely, with coordination between services and in collaboration with the resident and their whānau. Risks and current support needs had been identified, documented, and managed to ensure continuity of care. Options to access other health, disability, or social and cultural

whānau receive the necessary support during their transition, transfer, and discharge. As service providers: We ensure the people using our service experience consistency and continuity when leaving our services. We work alongside each person and whānau to provide and coordinate a supported transition of care or support.		support services were discussed where appropriate. When residents had been transferred to hospital, safe discharge and transfer processes were followed. Clear policies and guidelines were in place to ensure effective communication, documentation, and handover between Dixon House staff, hospital teams, and whānau. Whānau reported being kept well informed throughout the transfer process and expressed confidence that residents' needs were managed safely and respectfully.
Subsection 4.1: The facility The people: I feel the environment is designed in a way that is safe and is sensitive to my needs. I am able to enter, exit, and move around the environment freely and safely. Te Tiriti: The environment and setting are designed to be Māori-centred and culturally safe for Māori and whānau. As service providers: Our physical environment is safe, well maintained, tidy, and comfortable and accessible, and the people we deliver services to can move independently and freely throughout. The physical environment optimises people's sense of belonging, independence, interaction, and function.	PA Moderate	Dixon House, built in 1970, provides aged residential care for up to 42 residents across 37 rooms in four wings, with one wing containing five rooms being located upstairs. The rooms upstairs were accessible by a small lift or staircase and were occupied by rest home residents who can mobilise independently. The remaining rooms downstairs consist of five double occupancy one-bedroom flats, and 27 single occupancy rooms. There was a current building warrant of fitness, expiring 1 July 2026. The lift had been serviced and maintenance work completed in August 2024. A maintenance person is employed on a casual basis, working only the hours needed to complete the work requested of them. They complete the repairs/maintenance identified by staff and were responsible for all electrical safety testing. This was verified to have been completed, including for residents' own electrical equipment. Biomedical testing and calibration of equipment is completed by an external contractor annually and was last completed in October 2024. Evidence was sighted that this retesting was scheduled to occur in October 2025. Monthly hot water tests were completed for resident areas; these were sighted and were within the required temperature range. There was a process in place to address any deviations in water temperatures using tempering valves. The environment was spacious and accessible; corridors are wide and have handrails promoting independence and safe mobility. Personalised equipment was available for residents with disabilities to meet their needs. Rooms for residents requiring hospital-level care allowed space for the use of moving and handling equipment.

		Care staff interviewed stated they have adequate equipment to safely deliver care for residents. Space was available for the storage and charging of electronic mobility aids. There are adequate numbers of accessible bathroom and toilet facilities throughout the facility; however, one shower room had not been maintained to an acceptable standard and another was being used to store equipment; refer criterion 4.1.2. Accessible toilet facilities are available for staff and visitors. Outside areas for resident use had not been maintained. A gardener employed full time was making improvements to the garden areas. However, landscaping, paving of walkways, outdoor furniture, and areas to provide seating and shade for residents were all in need of repair and maintenance. An outdoor area being used as a smoking area was immediately outside the resident lounge windows; refer criterion 4.1.2. The GM reported that outdoor furniture had not been purchased in their eight years at the facility, although some had been donated. Interior and exterior maintenance was required to the building, including to an outside wall which had been identified as rotten. The board were aware of the problems and were seeking funding. The board chair confirmed that little maintenance to the building had occurred in the last four years due to the uncertainty about the continuance of the service; refer criterion 4.1.2. However, a new telephone system had been installed, and the call bell system was being upgraded at the time of audit. Rooms were personalised according to the residents' preferences. Residents and whānau interviewed were happy with the environment, including heating and ventilation, natural light, privacy, and maintenance. The current environment is inclusive of peoples' cultures and supported cultural practices. There had been no new building, but a process was in place to ensure consultation or co-design with Māori would occur if a new building was designed. Partial Provisional Audit Dixon House currently has 20 dual-purpose beds on the ground

		floor. The service has requested to convert all remaining downstairs beds (17) to dual-purpose hospital/rest home beds. This includes five double occupancy one-bedroom flats which are currently certified to provide either two rest home-level beds or one hospital-level and one rest home-level bed. In addition, the service wishes to convert a small lounge into a resident room (dual purpose) to be used primarily for end-of-life care. Emails were sighted which confirmed these changes are supported by Te Whatu Ora. All downstairs single occupancy rooms were found to be sufficiently spacious and appropriate for hospital-level care. All rooms would allow for moving and handling equipment to be used. All have appropriately situated call bells. All rooms are sufficiently close to the nurse's station to allow for prompt assistance when needed. Doorways are a standard doorway width and would not allow a resident to be moved out of the room on a bed but would allow transfer by ambulance trolley. In the case of the double occupancy rooms, there is sufficient space for two single hospital beds with space to allow for moving and handling. The rooms can accommodate two call bells. The rooms are currently only used for couples. However, there were no dividing curtains or screens to allow for privacy between the two residents; refer criterion 4.1.2. The lounge area was found to be appropriate for use as a resident room, and the service had converted another area within the facility to a small sitting area / library to mitigate the loss of the lounge space. There are sufficient bathroom and toilet facilities available for the changes proposed once repairs to the shower room identified under criterion 4.1.2 have been made. The service has identified equipment required for the proposed increase in hospital-level residents.

Subsection 4.2: Security of people and workforce The people: I trust that if there is an emergency, my service provider will ensure I am safe. Te Tiriti: Service providers provide quality information on emergency and security arrangements to Māori and whānau. As service providers: We deliver care and support in a planned and safe way, including during an emergency or unexpected event.	PA Low	The fire evacuation plan was approved by Fire and Emergency New Zealand (FENZ) on 6 May 2003. Staff attend regular fire drills (last held 29 July 2025), and those interviewed knew what to do in an emergency. Disaster and civil defence plans and policies direct the facility in its preparation for disasters and described the procedures to be followed. Staff have received relevant information and training and have appropriate equipment to respond to emergency and security situations. Adequate supplies for use in the event of a civil defence emergency meet The National Emergency Management Agency recommendations for the region; this included a 1,000L water tank, food supplies, a generator which is regularly tested, and a barbeque for cooking. Staff can provide a level of first aid relevant to the risks for the type of service provided and there was a staff member of duty with a first aid certificate on each shift on the rosters sighted. Call bells are situated in all resident rooms (including two calls bells in double occupancy rooms), bathrooms and communal areas, and alert staff to residents requiring assistance. Residents and whānau reported that staff respond promptly to call bells. The system was in the process of being upgraded at the time of audit. Appropriate security arrangements were in place. Staff were identifiable through name badges and uniforms. The facility has overnight 'lock-up' procedures which allow entry after hours, and for emergency egress. Information on emergency and security arrangements was provided to residents and their whānau on entry to the service. Partial Provisional Audit There is a current approved fire evacuation plan which describes the fire cells in place at Dixon House. Residents are only evacuated when the service is instructed to do so by the fire department. However, consideration of the needs of an increased number of higher acuity hospital-level residents who may require evacuation

		from the proposed newly designated dual-purpose rooms has not yet occurred; refer criterion 4.2.2. The upgraded call bell system will be appropriate for the changes proposed.
Subsection 5.1: Governance The people: I trust the service provider shows competent leadership to manage my risk of infection and use antimicrobials appropriately. Te Tiriti: Monitoring of equity for Māori is an important component of IP and AMS programme governance. As service providers: Our governance is accountable for ensuring the IP and AMS needs of our service are being met, and we participate in national and regional IP and AMS programmes and respond to relevant issues of national and regional concern.	FA	The infection prevention (IP) and antimicrobial stewardship (AMS) programmes, developed by an external advisor, were appropriate to the size and complexity of the service, have been approved by the governing body, link to the quality improvement system, and had been reviewed and reported on yearly. Expertise and advice are sought following a defined process, including from Te Whatu Ora, and the GP. A documented pathway supports risk-based reporting of progress and included escalation of significant events. Infection prevention and AMS information is discussed at the facility level and reported to the board at board meetings. Partial Provisional The current IP and AMS programmes are appropriate to support the inclusion of additional hospital-level care residents and can be scaled or adapted as necessary to address any increased risk or complexity associated with higher acuity care.
Subsection 5.2: The infection prevention programme and implementation The people: I trust my provider is committed to implementing policies, systems, and processes to manage my risk of infection. Te Tiriti: The infection prevention programme is culturally safe. Communication about the programme is easy to access and navigate and messages are clear and relevant. As service providers: We develop and implement an infection prevention programme that is appropriate to the needs, size, and scope of our services.	PA Low	The infection prevention control coordinator (IPCC) at Dixon House was responsible for overseeing and implementing the infection prevention and control (IPC) programme, with clear reporting lines to senior management and the board. The IPCC had appropriate skills for the role and confirmed access to external support as needed. However, they have not yet completed formal education in IP and AMS relevant to the role; refer criterion 5.2.1. The IP programme, developed by an external advisor, had been approved by the governing body, was linked to the quality improvement system, and had been reviewed and reported on

		yearly. The advice of the IPCC and the infection control committee is sought when making decisions related to procurement of clinical supplies, care delivery, and during the planning or design of any new building or facility changes. Infection prevention and control policies reflect the requirements of the current standard and are based on recognised good practice. The service works in partnership with Māori, and cultural advice is accessed where appropriate to ensure culturally safe practice. Staff were familiar with the policies through orientation and ongoing education and were observed following correct infection prevention and control (IPC) procedures during the audit. Residents and whānau receive education about infection prevention in ways that meet their individual needs, and educational materials were available in te reo Māori. A pandemic and infectious diseases response plan was documented, regularly reviewed, and has been tested through drills. There were sufficient resources and personal protective equipment (PPE) available, and staff were trained in their correct use. Staff were familiar with the policies and procedures for the decontamination and reprocessing of reusable medical devices. Evidence confirmed that these were cleaned and reprocessed appropriately, and that the process was routinely audited to ensure ongoing compliance with best practice. Single-use medical devices are not reused unless a formal risk assessment and governing body approval have been obtained. Partial Provisional IPC systems at Dixon House are sufficient to support an increase in hospital-level care residents. The IPC programme, environmental oversight, and staffing capacity can be adjusted as required to meet the higher acuity and complexity of care associated with additional residents.

Subsection 5.3: Antimicrobial stewardship (AMS) programme and implementation The people: I trust that my service provider is committed to responsible antimicrobial use. Te Tiriti: The antimicrobial stewardship programme is culturally safe and easy to access, and messages are clear and relevant. As service providers: We promote responsible antimicrobials prescribing and implement an AMS programme that is appropriate to the needs, size, and scope of our services.	FA	Responsible use of antimicrobials is actively promoted at Dixon House. The AMS programme was appropriate for the size and complexity of the service and was supported by comprehensive policies and procedures. On the day of audit, an AMS monthly antimicrobial usage report was sighted, demonstrating that the facility actively monitors and tracks all antimicrobial use. Antimicrobials were not prescribed unless residents were symptomatic or laboratory cultures had confirmed an infection. This ensures that antimicrobial use is clinically justified and consistent with best practice. The IPCC and GP demonstrated strong knowledge and a proactive approach to antimicrobial management. The effectiveness of the AMS programme is regularly evaluated through ongoing monitoring of antimicrobial use and identification of areas for improvement. Partial Provisional The antimicrobial stewardship programme at Dixon House is appropriate to support any additional hospital-level care residents and will be scaled or adjusted as required to meet the increased clinical complexity associated with higher acuity care.
Subsection 5.4: Surveillance of health care-associated infection (HAI) The people: My health and progress are monitored as part of the surveillance programme. Te Tiriti: Surveillance is culturally safe and monitored by ethnicity. As service providers: We carry out surveillance of HAIs and multi-drug-resistant organisms in accordance with national and regional surveillance programmes, agreed objectives, priorities, and methods specified in the infection prevention programme, and with an equity focus.	FA	Surveillance of health care-associated infections (HAIs) at Dixon House was appropriate to the type of services provided and aligns with the risks and priorities defined in the IP programme. Monthly surveillance data is collected using standardised definitions and analysed to identify trends, causative factors, and areas requiring action. Surveillance included ethnicity data, enabling equitable monitoring of infection patterns across different population groups. Notice boards within the facility displayed current infection surveillance information for staff, including details of all infections, ethnicity data, and control measures in place. This promotes staff awareness and engagement in infection prevention practices. Monthly surveillance reports were presented to the board, and the board chair demonstrated awareness of the findings and outcomes.

		Results of surveillance activities were discussed with staff, and any required improvements were identified. However, improvements were not always implemented; refer criterion 2.2.2. A summary report for a recent infection outbreak was reviewed and showed a thorough process of investigation, follow-up, and communication. Learnings from the event have been incorporated into current practice to prevent recurrence. Communication between service providers and residents experiencing HAIs is managed in a culturally safe and respectful manner, ensuring residents and whānau are informed and supported throughout. Partial Provisional Surveillance activities and reporting processes are in place and will be extended as required to include any additional hospital-level care residents admitted to the service.
Subsection 5.5: Environment The people: I trust health care and support workers to maintain a hygienic environment. My feedback is sought on cleanliness within the environment. Te Tiriti: Māori are assured that culturally safe and appropriate decisions are made in relation to infection prevention and environment. Communication about the environment is culturally safe and easily accessible. As service providers: We deliver services in a clean, hygienic environment that facilitates the prevention of infection and transmission of antimicrobialresistant organisms.	FA	A clean and hygienic environment at Dixon House supported the prevention of infection and the mitigation of transmission of antimicrobial-resistant organisms. Staff follow clearly documented policies and procedures for the safe management of waste, including infectious and hazardous substances. Staff responsible for cleaning and laundry have completed relevant training and were observed carrying out their duties safely and effectively. Policy described the monitoring of the laundry and cleaning processes through internal audits. However, these had not been completed since May 2023; refer criterion 2.2.2. The IP personnel have oversight of the environmental testing and monitoring programmes. All chemicals are appropriately labelled, securely stored in locked cupboards, and managed in accordance with safety requirements. Cleaning trolleys were observed to be well organised, fully stocked, and maintained in a hygienic condition. Material Safety Data (MSD) sheets were current and easily accessible to staff.

		The laundry facility was well designed, with a clear separation between dirty and clean areas to prevent cross-contamination. A designated area is used for folding clean laundry, and there is access to additional dryers within the facility to support operational efficiency. Dedicated sluice areas are available for managing soiled or infectious items, and a specifically designed space is provided for contaminated or infectious linen, located away from the main laundry area. This ensured safe handling and containment of infectious materials. The staff member responsible for the laundry service was well-trained, knowledgeable, and demonstrated competence in infection control practices, including the handling and segregation of contaminated linen. Residents and whānau reported that the laundry service operates efficiently, and that the facility is consistently clean and well maintained. These observations were confirmed during the audit. Partial Provisional The facility's cleaning and laundry services are suitable for supporting additional hospital-level care residents and will be adjusted as necessary to meet any increased or specialised needs.
Subsection 6.1: A process of restraint The people: I trust the service provider is committed to improving policies, systems, and processes to ensure I am free from restrictions. Te Tiriti: Service providers work in partnership with Māori to ensure services are mana enhancing and use least restrictive practices. As service providers: We demonstrate the rationale for the use of restraint in the context of aiming for elimination.	FA	The governing body demonstrated a commitment to maintaining a restraint-free environment. The CNM, who acts as the RC, described the focus on maintaining a restraint-free environment and has completed education relevant to the role. Restraint processes were understood by staff interviewed, who also described their commitment to maintaining a restraint-free environment. There were strategies in place to eliminate restraint, including an investment in processes and equipment to support the removal of restraint, for example, use of high/low beds, and sensor equipment. Restraint (bedrails) was last used in May 2025 . There were no residents observed to be using a restraint during the audit. Policies and procedures met the requirements of the standard and had been approved by the board. The RC role was defined in policy

		and provides support for staff and oversight of the restraint process. Staff have been educated in the least restrictive practices, safe restraint practice, alternative cultural-specific interventions, de-escalation techniques for responsive behaviours, and restraint monitoring as part of the orientation programme and then through ongoing education and annual competency assessments. The restraint approval group meets six-monthly, and as required, and is responsible for the approval of the use of restraints. Policy and procedures include all documentation required for the safe use of restraint, should this be required in the future. Decisions are multidisciplinary and involve whānau as appropriate. A restraint register was maintained on the electronic resident management system; the criteria on the restraint register contains enough information to provide an auditable record of restraint should this be required. Documentation related to the last use of restraint in May 2025, including entry on the restraint register, was sighted. Any use of restraint is reported to the governing body. The RC undertakes a six-monthly audit to confirm policy is being followed. Any changes to policies, guidelines, education, and processes are implemented if indicated. Six-monthly reports to the board of trustees were sighted. Given no restraint was being used in the facility, subsections 6.2 and 6.3 have not been audited.

Specific results for criterion where corrective actions are required

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

Criterion can be linked to the relevant subsection by looking at the code. For example, Criterion 1.1.1 My service provider shall embed and enact Te Tiriti o Waitangi within all its work, recognising Māori, and supporting Māori in their aspirations, whatever they are (that is, recognising mana motuhake) relates to subsection 1.1: Pae ora healthy futures in Section 1 Our rights.

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.8.3 My complaint shall be addressed and resolved in accordance with the Code of Health and Disability Services Consumers’ Rights.	PA Low	Policy in place meets all requirements of the standard and the Code. The general manager described the processes followed, which included acknowledgement of the complaint verbally by telephone or in person, investigations, and meeting with complainants to inform them of the finding of investigations and the outcome of the complaint. However, acknowledgements and meetings were not documented, and the service was unable to demonstrate that the timeframes required by policy and the Code were met.	Acknowledgement of complaints and responses to complaints were not documented. As a result, evidence was not available to confirm that the timeframes for acknowledgement of complaints and responses to complainants required by policy and the Code were met.	Ensure all aspects of complaints management, including the acknowledgement of complaints and reporting of outcomes to complainants, are documented as described in policy and in line with the Code. 180 days
Criterion 1.8.4 I am informed of the findings of my	PA Low	The policy in place described the documentation required in relation to complaints management, including	Complaint responses were not documented, complainants did not receive a written response	Ensure all aspects of complaint management are documented, including written responses to

complaint.		responding to complainants in writing. However, the general manager reported that complainants were informed of the finding of any complaint investigations verbally and this was not documented. Evidence was not available to confirm complainants had been informed of the findings of their complaint.	as required by policy, and no evidence was available to confirm complainants were notified of the outcome/findings of their complaint.	complainants outlining the findings of complaint investigations as required by policy. 180 days
Criterion 2.1.10 Governance bodies shall have demonstrated expertise in Te Tiriti, health equity, and cultural safety as core competencies.	PA Low	No evidence was available to confirm that the board of trustees had completed training on, and could demonstrate expertise in, Te Tiriti, health equity or cultural safety.	The service was unable to confirm that the board of trustees had completed training on, and could demonstrate expertise in, Te Tiriti, health equity or cultural safety.	Provide evidence that the board of trustees have completed training which enables them to demonstrate expertise in Te Tiriti, health equity or cultural safety. 180 days
Criterion 2.2.2 Service providers shall develop and implement a quality management framework using a risk-based approach to improve service delivery and care.	PA Moderate	There is a documented quality management framework that describes the principles of continuous quality improvement. The framework includes the reporting and analysis of incidents and adverse events, infection surveillance, internal audits, resident satisfaction measures, and complaint management. Policy described the processes for corrective action planning to address shortfalls identified and the use of a Plan Do Study Act (PDSA) framework for quality improvement planning. Quality activities, including the reporting of incidents, were discussed at a range of meetings, including meetings for registered nurses (RNs), all staff, health and safety, and infection prevention.	Not all elements of the quality framework, as described in policy and detailed above, had been fully implemented.	Ensure the quality framework described in policy is fully implemented, and that all quality activities described in policy are completed. Ensure that corrective action planning and quality improvement planning are documented to address shortfalls identified, and that plans include evaluation of improvements. Ensure meeting minutes are sufficiently detailed to evidence what has occurred, what decisions are made, actions required, identify who is assigned responsibility, and that actions

		However, not all elements of the quality system had been fully implemented: • Not all internal audits described in the schedule had been completed, including no cleaning or laundry audits since May 2023. • Corrective actions were not implemented to address deficits identified through resident surveys, internal audits, the complaints process, and infection surveillance activities. • Meeting minutes were not sufficiently detailed to identify what had occurred and did not document decisions made or actions to be taken or identify the person responsible for follow-up actions. • Quality improvement plans were not always documented, and documentation sighted did not evidence a process of evaluation and follow-up to confirm improvement had been made.		are followed up at the next meeting. 90 days
Criterion 2.2.4 Service providers shall identify external and internal risks and opportunities, including potential inequities, and develop a plan to respond to them.	PA Moderate	Dixon House had a risk register in place, created using a template provided by the external clinical and compliance advisor. Risks were described under heading, related to pandemic, staffing/skill deficit, restraint, environment/equipment, maintenance, and laundry/kitchen. Risks had been assigned a rating of high, medium or low based on the likelihood of occurrence and the severity of its consequences. The register described mitigation strategies in place. The GM described reviewing and updating the risk	There was a risk register in place which had been reviewed and updated. However, not all identified risks had been included, mitigation strategies were not in place for all risks, and not all risks identified as high risk had been reported to or reviewed by the governing body.	Ensure that all risks are included on the risk register, that elimination or mitigation occurs as appropriate, and that all risks identified as high risk are reviewed by the board of trustees. 90 days

		register six-monthly. This had occurred on 25 July 2025 with input from the ENCC but not from the board, the CNM or other staff. The risk register was not included in reports to the board sighted (three), and board meeting minutes did not evidence review of risks detailed on the register. When interviewed, the GM stated that risks, including high-risk issues, were not routinely reported to the board. Evidence was sighted of some risks related to the environment being reported to and discussed by the board when funding was required for elimination or mitigation of the risk; for example, risks related to the failing call bell system, which was being updated on the day of audit. Not all risks identified by the organisation, or by the auditors on the days of audit, were included in the risk register. This included trip hazards in the outdoor areas caused by uneven pavers, rusted and disintegrating metal outdoor umbrella holders (two) which remained on the outdoor terrace and were a hazard to residents, an outdoor water feature/pond with no protection, an unfenced outdoor garden area for resident use with a two metre drop to the garden and path below, a shower room with damaged wall lining and damage to the underlying wall structure identified by the maintenance person as unhygienic and unrepairable (note: this remained in use), and an exterior damaged/rotting wall. While the board of trustees were aware of some of these hazards, and funding was being sought for repairs, they were not		

		documented as risks and no elimination or mitigation strategies had been put in place (refer criterion 4.1.2).		
Criterion 2.3.1 Service providers shall ensure there are sufficient health care and support workers on duty at all times to provide culturally and clinically safe services.	PA Moderate	A Dixon House staffing formula worksheet was available to determine the daily and weekly hours for RNs and caregivers to provide culturally and clinically safe care 24/7. This was developed by an external consultant. The formula adjusts staffing levels based on the acuity of residents and their assessed level of care. The formula worksheet had not been used regularly; data was available to show required hours in June and December 2024 and was recalculated on the day of audit. As the resident population had been stable, this showed only minor fluctuation in the required RN and caregiver hours. Review of six weeks of rosters confirmed that caregiver hours met the required level identified from the formula described above, and that replacement occurred when a staff member was on leave. The rosters confirmed there was always at least one RN on duty 24/7. However, even including the total CNM hours in the calculation, the base roster showed a deficit in RN hours of 46 hours per week and up to 11 hours per day at the weekend when reviewed against the RN hours required by the staffing formula. The CNM hours being included do not account for time to be available for managerial functions and clinical oversight of staff.	Review of the roster showed there were insufficient RNs on duty to meet the needs of the residents as determined by the provider's safe staffing formula. Inclusion of the CNM in the RN roster meant that the CNM had insufficient time for managerial functions and oversight of clinical services for residents in the service. Recruitment for increased caregiver and RN hours required for an increase in the number of hospital-level residents had not yet begun and funding had not been approved for recruitment.	Provide evidence that the rostered RN hours are in line with the safe staffing formula employed at the facility. Provide evidence that, prior to increasing the number of hospital level residents, there is adequate staffing in line with the staffing formula and that rostered RN hours are sufficient to allow for the CNM to complete managerial functions and have oversight of clinical services. 30 days

Criterion 2.4.1 Service providers shall develop and implement policies and procedures in accordance with good employment practice and meet the requirements of legislation.	PA Low	Policy described the requirement for police vetting of all staff and volunteers to occur prior to employment. Evidence that this had occurred was not available in seven of ten files reviewed. Requests for police vetting were sent on the day of audit; for this reason, the risk rating has been assessed as low.	Seven of ten staff files reviewed had no evidence that police vetting had occurred.	Ensure that police vetting occurs for all new staff and volunteers on employment. 180 days
Criterion 2.4.5 Health care and support workers shall have the opportunity to discuss and review performance at defined intervals.	PA Low	Policy described the process for performance appraisals to occur annually for all staff. Evidence of this occurring for nursing staff was sighted. All files for caregivers reviewed (five) had a completed performance appraisal. However, interview with staff, the GM and the ENCC responsible for caregiver appraisals confirmed this was a staff self-assessment and they did not meet with staff to review and discuss performance unless this was specifically requested by the staff member. The ENCC had added comments to each performance appraisal; however, evidence was not available to confirm these had been seen by the staff member. Staff interviewed, including caregivers, laundry, and kitchen staff, confirmed that they had not met with anyone to review or discuss their performance (in up to eight years in one instance).	Caregivers completed a self-assessment of performance but had not had an annual performance appraisal that included the opportunity to review and discuss their performance as defined in policy.	Ensure that all staff have a performance appraisal that includes the opportunity to review and discuss their performance, as described in policy. 180 days
Criterion 3.5.4	PA Low	A full rotating menu was observed on the	The organisation has not yet	Provide evidence that the menu

The nutritional value of menus shall be reviewed by appropriately qualified personnel such as dietitians.		day of audit. The menu operates on a multi-week cycle to ensure residents are provided with variety and balanced meal options. While the menu had been viewed by a dietitian, it has not yet been formally signed off as meeting nutritional requirements. The dietitian recommended updates to align the menu with current best practice, and this review process is currently underway but remains incomplete.	finalised the dietitian's review or implemented the recommended updates to dietary menu options.	has been reviewed by a suitable qualified person such as a dietitian and that any recommendations have been implemented. 180 days
Criterion 4.1.2 The physical environment, internal and external, shall be safe and accessible, minimise risk of harm, and promote safe mobility and independence.	PA Moderate	The environmental maintenance schedule as documented had not been fully implemented and not all urgent maintenance identified had been carried out, resulting in degradation of the environment: • A shared resident shower where the wall lining was no longer intact, leading to damage to the underlying structure. The area was unable to be maintained to a satisfactory level of cleanliness. • Paved areas outside resident rooms were uneven, creating an unsafe trip/falls hazard; this was not identified on the risk register. • Outside areas for resident use had not been maintained; no new outdoor furniture had been purchased in at least eight years, and existing furniture had not been maintained. • An area designated for resident use outside the main lounge was being	The environment maintenance schedule as documented had not been fully implemented and not all urgent maintenance identified had been carried out, resulting in degradation of the environment. There was no safe and appropriate outdoor area for residents to use with shade and seating. Environmental hazards had not all been eliminated or mitigated.	Ensure that the maintenance schedule is implemented. Ensure that there is a safe and appropriate outdoor area for resident use that includes shade and seating. Ensure screens or dividing curtains are available to ensure privacy for individual residents when required. Ensure that outdoor hazards are eliminated or mitigated. 90 days

		used as a smoking area. • An outside wall on the northeast-facing resident rooms had been identified as rotting and requiring repair. • Hazards in the resident outdoor areas had not been identified and mitigated; including rusted and disintegrating metal umbrella stands with sharp edges, a water feature pond with no protection, and an unfenced area with a two-meter drop to a garden and pathway. Repairs required had been made known to the governing body, but funding approval was not in place to enable work to be conducted. Double rooms had no screens or dividing curtains to ensure privacy for the individual residents.		
Criterion 4.2.2 Service providers shall ensure there are implemented fire safety and emergency management policies and procedures identifying and minimising related risk.	PA Low	The service has an approved fire evacuation plan for the facility. However, consideration of the needs of an increased number of higher acuity hospital-level residents has not yet occurred. Prior to an increase in the number of hospital-level residents, the service is required to: • Consider the evacuation needs of hospital-level residents in the proposed newly designated dual-purpose rooms. • Confirm with FENZ that the current plan will continue to be appropriate for a higher number of non-mobile	The service had not confirmed with FENZ that the fire evacuation plan will be appropriate for a proposed higher number of non-mobile residents.	Ensure that, prior to increasing the number of hospital level residents, confirmation is sought from FENZ that the fire evacuation plan remains appropriate and that there are sufficient resources and equipment available for the evacuation of the increased number of higher acuities, non-mobile, residents. Prior to occupancy

		residents.		
Criterion 5.2.1 There is an IP role, or IP personnel, as is appropriate for the size and the setting of the service provider, who shall: (a) Be responsible for overseeing and coordinating implementation of the IP programme; (b) Have clearly defined responsibility for IP decision making; (c) Have documented reporting lines to the governance body or senior management; (d) Follow a documented mechanism for accessing appropriate multidisciplinary IP expertise and advice when needed; (e) Receive continuing education in IP and AMS; (f) Have access to shared clinical records and diagnostic results of people.	PA Low	The IP and AMS programmes at Dixon House were overseen by an RN who was the IPCC; they were knowledgeable in their role. The IPCC discussed processes around pandemic management, AMS oversight, and IP activities. While they had completed a course on hand hygiene, no further formal education on IP and AMS leadership relevant to the role had been completed. There were clearly documented reporting lines to the governance body, and infection data, including ethnicity information, had been regularly reported to the board. The IPCC accesses specialist advice and support from Te Whatu Ora infection prevention services and the GP when required.	The IPCC has not completed specific education in IP and AMS leadership relevant to the role.	Ensure the IPCC completes formal education and ongoing professional development in IP and AMS appropriate to their leadership responsibilities. 180 days

Specific results for criterion where a continuous improvement has been recorded

As well as whole subsections, individual criterion within a subsection 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 subsection by looking at the code. For example, Criterion 1.1.1 relates to subsection 1.1: Pae ora healthy futures in Section 1: Our rights.

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

No data to display

End of the report.