# Methven Aged Person's Welfare Association Incorporated - Methven House

## Introduction

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

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

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

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

The specifics of this audit included:

**Legal entity:** Methven Aged Person's Welfare Association Incorporated

**Premises audited:** Methven House

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

**Dates of audit:** Start date: 8 March 2017 End date: 8 March 2017

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

**Total beds occupied across all premises included in the audit on the first day of the audit:** 12

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

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

## General overview of the audit

Methven House provides rest home level care for up to 13 residents. On the day of audit 12 beds were occupied, including one resident receiving respite care. The service is operated by Methven Aged Person’s Welfare Association Inc. and is managed by a nurse manager with the support of a management committee.

This certification audit was conducted against the Health and Disability Service Standards and the service’s contract with the Canterbury District Health Board. The audit process included review of policies and procedures, review of residents’ and staff files, observations and interviews with residents, family members/whanau, management, staff and a general practitioner.

There are no areas requiring improvements and one area of continuous improvement in relation to quality and risk management.

## Consumer rights

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

The Health and Disability Commissioner’s Code of Health and Disability Services Consumers’ Rights (the Code) is made available to residents. Opportunities to discuss the Code, consent and availability of advocacy services is provided at the time of admission and thereafter as required.

Services are provided that respect the choices, personal privacy, independence, individual needs and dignity of residents. Staff were noted to be interacting with residents in a respectful manner.

Currently there are no residents who identify as Māori, however relevant policies are in place that would protect the cultural values and beliefs of people who identify as Māori. A comprehensive Māori health plan and related policies guide care. There was no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are maintained.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to formal interpreting services if required. The service has linkages with a range of specialist health care providers, which contributes to ensuring services provided are of an appropriate standard. There is a complaints process that is understood by residents, family members and staff and meets the requirements of the Code. The nurse manager maintains a current register.

## Organisational management

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

Business and quality and risk management plans include the direction, goals, values and mission statements of the organisation. Monitoring of the services is provided by the governing body and is regular and effective. An experienced and suitably qualified person manages the rest home.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and feedback is sought from residents and families/ whanau. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and are current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery, and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of the residents. A resident information management system is in place and information is entered in a timely and accurate manner. Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable.

## Continuum of service delivery

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| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Standards applicable to this service fully attained. |

The organisation works closely with the local Needs Assessment and Service Coordination Service (NASC), to ensure access to the facility is appropriate and well managed. When a vacancy occurs, relevant information is provided to the potential resident/family/whanau to facilitate the admission.

Residents’ needs are assessed by the multidisciplinary team on admission, within the required timeframes. The nurse manager, who is a registered nurse, and another registered nurse are on duty during the day and available on call after hours for the facility. The nurse manager and registered nurse are supported by care and allied health staff and designated general practitioners. Shift handovers and communication sheets guide continuity of care.

Care plans are individualised, based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that might arise. All residents’ files reviewed demonstrated that needs, goals and outcomes were identified and formerly reviewed six monthly in accordance with contractual requirements. All residents are fully assessed and reassessed using the interRAI assessment process and reviews were current and well managed.

All residents are regularly reviewed by the GP and progress documented. The GP reports that medical treatment plans are consistently followed and medical support sought in a timely manner. Residents and families/whanau interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

The planned activity programme meets the needs and preferences of residents in a meaningful individual and group programme and maintains their links with the community. Medicines are managed according to policies and legislation and consistently implemented using a manual system. Medications are administered by trained staff who are competent to do so. Records for controlled drugs and for prescribing and administration were maintained.

The food service meets the nutritional needs of the residents. Personal likes and dislikes are catered for and special events celebrated. The facility has a productive garden of fresh vegetables. Current policies guide safe food service delivery, supported by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. Residents verified satisfaction with meals.

## Safe and appropriate environment

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

There are documented emergency management response processes which were understood and implemented by staff. This includes protecting residents, visitors and staff from harm as a result of exposure to waste or infectious substances.

The building has a current building warrant of fitness and the service has an approved fire evacuation plan. There have been no changes to the services being delivered or to the facility footprint since the previous audit.

Residents’ are provided with an environment that is appropriate to meet their needs as confirmed during resident interviews. There is adequate toilet, bathing and hand washing facilities. Designated lounge and dining areas meet residents' relaxation, activity and dining needs. Cleaning and laundry processes are appropriate to the setting, and staff are guided by policies and procedures to ensure residents are provided with a safe and hygienic facility.

The facility heating is electric with residents’ rooms having panel heaters and communal areas having heat pumps. Opening doors and windows creates a good air floor to keep the facility cool when required. The outdoor areas provide suitable areas to walk and shade for residents’ use.

## Restraint minimisation and safe practice

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

At the time of audit, no restraints or enablers were in use. Policies and procedures are available to staff, should restraint be required. Staff education is undertaken as part of orientation and as on-going in-service education. Staff demonstrated their understanding of the restraint minimisation policy and procedures and the definition of an enabler. Policy describes all restraint definitions to meet Health and Disability Services Standards requirements, including that of enablers, which are voluntary and used for a resident's safety or to help maintain independence.

## Infection prevention and control

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

The infection prevention and control programme, led by an appropriately trained infection control co-ordinator, aims to prevent and manage infections. The infection control programme is supported by the Board and overseen by a registered nurse, who supports staff education, reviews policies and procedures and maintains a surveillance programme. Staff receive updates on the incidence of infections at staff meetings as part of regular indicator reporting. Any special precautions are discussed in these forums. Surveillance is undertaken for a range of infections relevant to the long-term care environment. Rates of infection in the facility are very low. The programme is reviewed annually. Staff demonstrated good principles and practice around infection control.

## Summary of attainment

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement****(CI)** | **Fully Attained****(FA)** | **Partially Attained Negligible Risk****(PA Negligible)** | **Partially Attained Low Risk****(PA Low)** | **Partially Attained Moderate Risk****(PA Moderate)** | **Partially Attained High Risk****(PA High)** | **Partially Attained Critical Risk****(PA Critical)** |
| **Standards** | 0 | 45 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 1 | 92 | 0 | 0 | 0 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service DeliveryConsumers receive services in accordance with consumer rights legislation. | FA | Methven House has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers’ Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options to residents and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records. |
| Standard 1.1.10: Informed ConsentConsumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | The nurse manager, registered nurse and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed showed that informed consent has been gained appropriately using the organisation’s standard consent form including for photographs, outings, and invasive procedures.Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent, is defined and documented where relevant in the resident’s record. Staff demonstrated their understanding by being able to explain situations when this may occur. Staff were observed to gain consent for day to day care on an ongoing basis. |
| Standard 1.1.11: Advocacy And SupportService providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters related to the Advocacy Service were also displayed in the facility, and additional brochures were available at the entrance way. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons.Staff were aware of how to access the Advocacy Service and examples of their involvement were discussed at staff interviews.  |
| Standard 1.1.12: Links With Family/Whānau And Other Community ResourcesConsumers are able to maintain links with their family/whānau and their community.  | FA | Residents are assisted to maximise their potential for self-help and to maintain links with their family/whanau and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment. The facility supports the philosophy of ‘Quality of Life’, caring, and living life to the highest level of independence.The facility has unrestricted visiting hours and encourages visits from the residents’ family/whanau and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff. |
| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.  | FA | The complaints policy aligns with Right 10 of the Code. Information on the complaints process and a copy of residents’ rights is provided on entry and residents interviewed knew how to do so. Complaints forms are visible within the facility. A complaints register is in place, however there have been no complaints registered since the last audit. Complaints are a standard agenda item on the staff and management meeting agendas. |
| Standard 1.1.2: Consumer Rights During Service DeliveryConsumers are informed of their rights. | FA | Residents interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy service (Advocacy Service) by the Nurse Manager as part of admission process, from information provided, and from discussion with staff. The Code is displayed in the rest home in the entrance way (in English and Maori), the dining room and lounge. Consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that respects consumer rights, facilitates informed choice, minimises harm, and acknowledges cultural and individual values and beliefs. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And RespectConsumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | Residents and families/whanau confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices. Staff understood the need to maintain privacy and were observed doing so throughout the audit while attending to personal cares, and by ensuring resident information was held securely and privately. Most residents have a private room and three rooms are shared.Residents are encouraged to maintain their independence by staff ensuring individual care plans are followed, attending community activities, arranging their own visits to the podiatrist, dentist and participation in clubs of their choosing. Each plan included documentation related to the resident’s abilities and strategies to maximise independence. Records reviewed confirmed that each resident’s individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan. Staff understood the service’s policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for staff, and is then provided on an annual basis, as confirmed in staff and training records.  |
| Standard 1.1.4: Recognition Of Māori Values And BeliefsConsumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | Staff support residents in the service who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whanau to Māori residents. There is a current Māori health plan developed with input from cultural advisers. Current access to resources includes the contact details of local cultural advisers. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility. At the time of audit, there were no Maori residents in the facility. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And BeliefsConsumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.  | FA | Residents verified that they were consulted on their individual culture, values and beliefs and that staff respect these. Resident’s personal preferences, required interventions and special needs were included in all care plans reviewed. Residents had dietary preferences and spiritual preferences documented. Interviews confirmed that staff ensure the residents’ needs are met. A resident satisfaction questionnaire includes evaluation of how well residents’ cultural needs are met and this supports that individual needs are being met. |
| Standard 1.1.7: DiscriminationConsumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Residents and family/whanau members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. A general practitioner interviewed also expressed satisfaction with the standard of services provided to residents. The induction process for staff includes education related to professional boundaries and expected behaviours. Staff are provided with a Code of Conduct in both the staff orientation booklet and their individual employment contract. Ongoing education is also provided on an annual basis, which was confirmed in staff training records. Staff are guided by policies and procedures and, when interviewed, demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring. |
| Standard 1.1.8: Good PracticeConsumers receive services of an appropriate standard. | FA | The service encourages and promotes good practice through evidence based policies, input from external specialist services and allied health professionals, for example, hospice/palliative care team, diabetes nurse specialist, physiotherapist, occupational therapist, wound care specialist, mental health services for older persons, and education of staff. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests. Staff reported they receive management support for internal and external education through Careerforce training and there was evidence of a compulsory plan for all staff where staff are booked to attend education to support contemporary good practice.Other examples of good practice observed during the audit included extra fluid rounds, prompt answering of call bells, regular toileting rounds, and pressure injury prevention strategies. |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents and family/whanau members stated they were kept well informed about any changes to their relative’s status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents’ records reviewed. There was also evidence of resident/family/whanau input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. Interpreter services can be accessed via the DHB or Older Persons Health when required. Staff knew how to do so, although reported this was rarely required due to all residents able to speak English.  |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | The strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The mission statement has recently been rewritten to better reflect the ethos of the organisation; this change was generated by the staff. The plans describe annual and longer term objectives and the associated operational plans. All staff employed are aware of the business plan and its contents, to ensure they are aware of the direction the business is moving and their role within it.A sample of monthly reports to the management committee showed adequate information to monitor performance is reported including emerging risk, financial information, health and safety reporting requirements and day to day operational information. The management committee chairperson interviewed expressed satisfaction with the level of information received and reported a positive relationship with the nurse manager.The rest home is managed by a nurse manager who holds relevant qualifications and has been in the role for ten years. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The nurse manager maintains her own professional development. Residents were very complimentary and appreciative of the commitment of the nurse manager. |
| Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.  | FA | When the nurse manager is absent, the registered nurse carries out all the required duties under delegated authority. A board member, who is also a registered nurse with a current practising certificate, is able to assist as needs arise. Staff interviewed felt well supported by the nurse manager and registered nurse and find them approachable. The nurse manager receives support from the management committee when required.  |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes internal audit activity, regular patient satisfaction surveys, management of incidents and complaints. If an issue or deficit is found a recommendation is written and corrective actions are put in place to address the situation. Information is shared with all staff as confirmed in meeting minutes sighted and verified by staff interviewed.Meeting minutes reviewed, confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the management committee meeting and staff meetings. Where required information is taken to the Methven House Board. Staff interviewed understood their responsibilities in the quality system appropriate to their role and have been encouraged by management to participate in quality activities such as internal audits and reviewing of the mission statement. Resident and family surveys are undertaken with the most recent results showing a high level of satisfaction with services and the environment. The policies reviewed cover all necessary aspects of the service and contractual requirements. A document control system has been implemented and there is a process in place to ensure the nurse manager reviews and makes any necessary corrections to documents, which are then approved by the committee. Only the administrator can physically change any documents. A quality consultant oversees the management of the controlled documents and provides the service with any new information that aligns with good practice and any legislative or regulatory changes. Staff sign confirmation that they have read any changed or new documents. Actual and potential risks are identified using the quality and risk planning processes. Newly found hazards are discussed at staff meetings and residents are informed as appropriate. Staff confirmed that they understood and implemented documented hazard identification processes. The hazard register sighted covers all aspects of service delivery. A current hazard identified is the carpet area inside the front door, it is awaiting replacement, however until this time, a staff member is responsible to check daily that the area remains taped and residents are reminded to beware daily. Recently the Health and Safety Officer and committee have undertaken a rigorous review of all health and safety matters due to the new Health and Safety at Work Act (2015), and implemented many initiatives all of which have been well received by staff and residents.  |
| Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.  | FA | Policy identifies that the organisation requires all incidents, accident and adverse events to be reported immediately. The nurse manager fully understands the requirements of her role to report falls and pressure injuries on a section 31 incident notification form. Within the last year two notifications have been raised, one concerning a wondering patient and the other for a security breach, both have been completed and are now resolved. The latter event being reported to the police (refer 1.4.7), was documented in the corrective action register and correct process according to the policy followed. Documentation was thorough. No other investigations have been required. Staff interviewed stated they report and record all incidents and accidents and that this information was shared at management and board level of the organisation, and any follow up actions required were reported back to them. Incident and accident reporting processes are well documented and corrective actions taken are shown on the forms used by the service. Family/whānau confirmed during interview that they are notified of any adverse, unplanned or untoward events and/or any concerns the staff may have. Management confirmed that information gathered from incident and accidents is used as an opportunity to improve services where indicated. |
| Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.  | FA | Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes two referee checks, police vetting and validation of qualifications and practising certificates, where required. A sample of staff records reviewed confirmed the organisation’s policies are being consistently implemented and records are maintained.Staff orientation includes all necessary components relevant to the role. Staff interviewed reported that the orientation process prepared them well for their role. Staff records reviewed show documentation of completed orientation and a performance review after a three-month period.Continuing education is planned annually, including mandatory training requirements. The plan allows flexibility and extra sessions can be added throughout the year, as changes to practice occur or needs arise. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the contract. The nurse manager and registered nurse are competent and are maintaining their annual competency requirements to undertake interRAI assessments.Records reviewed demonstrated completion of the required training and completion of annual performance appraisals. Annual practising certificate verification was sighted for all visiting general practitioners and pharmacists. |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is a documented and implemented process for determining staff levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week. The facility adjusts staffing levels to meet the changing needs of the residents. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Caregivers reported there were adequate staff available to complete the work allocated to them. Residents and family / whānau interviewed supported this. In an unplanned absence caregivers currently employed at Methven House cover the required hours. All staff have current first aid certificates and this was supported in files reviewed. The activities coordinator works Tuesday to Friday and there are dedicated kitchen and cleaning staff seven days a week. The nurse manager and the registered nurse cover the afterhours on call roster. |
| Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The resident’s name, date of birth and National Health Index (NHI) number are used on labels as the unique identifier on all residents’ information sighted. All necessary demographic, personal, clinical and health information was fully completed in the residents’ files sampled for review.Clinical notes were current and integrated with GP and allied health service provider notes. Records were legible with the name and designation of the person making the entry identifiable.Archived records are held securely on site and are readily retrievable using a cataloguing system. Residents’ files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit. |
| Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families/whanau are encouraged to visit the facility prior to admission and meet with the nurse manager. They are also provided with written information about the service and the admission process. The service operates a waiting list for entry. The organisation seeks updates of information from NASC and the GPs for residents accessing respite care. Family/whanau members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.  | FA | Exit, discharge, or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate and there is open communication between all services, the resident and the family/whanau. At the time of transition between services, appropriate information, including medication records, 24 hours of medication, 24 hours of progress notes, wound charts (where applicable), and advance directives are provided for the ongoing management of the resident. A checklist ensures this occurs. All referrals are documented in the progress notes.  |
| Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. A safe system for medicine management using a blister pack system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage. Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by a registered nurse against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided Bi annually on site and on request, however the NM or RN visit the pharmacy to pick up the medication and discuss any situations that require input.Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six monthly stock checks and accurate entries. Verbal orders are rarely used but processes are in place to enable safe administration and appropriate documentation. The records of temperatures for the medicine fridge were within the recommended range. Good prescribing practices noted include the prescriber’s signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three monthly GP review was consistently recorded on the medicine chart. There were no residents who self-administer medications at the time of audit. Appropriate processes are in place to ensure this would be managed in a safe manner. Medication errors are reported to the NM and recorded on an incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA |  Food service is provided on site by the night caregiver, who is also a cook, and is supported by staff at Methven House who have all attended food safety training. Food service is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Residents have access to food and fluids to meet their nutritional needs at all times. Special equipment, to meet resident’s nutritional needs, is available.Evidence of resident satisfaction with meals was verified by resident and family/whanau interviews, satisfaction surveys and resident meeting minutes. Residents were observed to be given sufficient time to eat their meal and those requiring assistance had this provided. |
| Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.  | FA | If a referral is received, but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC service is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC service is made and a new placement found, in consultation with the resident and family/whanau. Examples of this occurring were discussed with the nurse manager (NM). There is a clause in the access agreement related to when a resident’s placement can be terminated. |
| Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | The RN confirmed during interview that prior to admission, the Central Care Coordination Centre (CCC) completes an interRAI assessment to ensure the placement is appropriate, and the NM makes the final decision based on the assessment. The RN completes an appropriate assessment on admission to the facility. The assessment includes a pressure area risk assessment, falls risk assessment, continence assessment, nutritional assessment and, if required, a wound assessment.An interRAI assessment was completed on new admissions as verified in records reviewed, and an updated care plan was completed based on the completed assessment. Resident, family/whanau input and appropriate allied health and community feedback is incorporated into the assessment. Reviews occur in a timely manner by the RN. If an issue arises within the evaluation period, an appropriate assessment tool was completed prior to the development of a short term care plan. Examples reviewed showed a consistent assessment and care planning process. |
| Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Information is documented using validated nursing assessment tools, such as a pain scale, skin integrity, nutritional screening, falls risk, continence assessment, activity assessment and depression scale, as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident related information. All residents’ files reviewed demonstrated six monthly interRAI assessments were being completed within the time frames required which then informed the six monthly care plan review. Interventions triggered in the interRAI assessment were included in all the care plans reviewed. |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. There is attention to meeting a diverse range of resident’s individualised needs in a sensitive manner which was evident in records reviewed. The GP interviewed expressed confidence in the service, and verified that medical input was sought in a timely manner, medical orders were followed, interventions and care was appropriate and timely. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents’ needs. |
| Standard 1.3.7: Planned ActivitiesWhere specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The activities programme is provided by one activities co-ordinator who has commenced the Careerforce diversional therapy training. A social assessment and history is undertaken on admission to ascertain residents’ needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident’s activity needs are evaluated as their needs change, monthly, and as part of the formal six monthly care plan review. The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents’ goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Examples included musicians playing music and singing, planned outings, individual outings, volunteers coming to read to residents, and children’s groups coming to visit.The activities programme is discussed at the minuted residents’ meeting and indicated residents’ input is sought and responded to. Resident and family/whanau satisfaction surveys demonstrated satisfaction with the programme and that information is used to improve the range of activities offered. Residents interviewed confirmed they find the programme encourages them to reach their highest level of independence within the limitations they have. |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the NM or RN. Formal care plan evaluations occur every six months or as residents’ needs change. Six-monthly interRAI reassessments are occurring, or more frequently as residents’ needs change. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans were consistently reviewed for urinary tracts infections (UTIs), falls, infections, any changes in the resident’s normal status. Progress was evaluated as clinically indicated, at least weekly, and according to the degree of risk noted during the assessment process. Other plans, such as wound management plans were evaluated each time the dressing was changed. Residents and families/whanau interviewed provided examples of involvement in evaluation of progress and any resulting changes. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.  | FA | Residents are supported to access or seek referral to other health and/or disability service providers. All residents have the choice of their own GP. If the need for other non-urgent services are indicated or requested, the GP, NM or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents’ files, including to the needs assessor, gerontology clinical nurse specialist, diabetes nurse specialist, wound care specialist, geriatrician, and older persons’ mental health services. Referrals are followed up on a regular basis by the registered nurse or the GP. The resident and the family/whanau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | The organisation’s waste management policy covers hazardous, controlled, and non-hazardous waste management. Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage was displayed. Waste is separated and clear signage as to what is deposited in what container was displayed.Material safety data sheets were available where chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur. There is provision and availability at all times of protective clothing and equipment and staff interviewed knew when to utilise this. |
| Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness was publicly displayed. It expires in June 2017.Appropriate systems are in place to ensure the residents’ physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio-medical equipment was current as confirmed in documentation reviewed and observation of the environment. Efforts are made to ensure the environment is hazard free, that residents are safe and independence is promoted.External areas are safely maintained and are appropriate to the resident group and setting. Residents confirmed they know the processes they should follow if any repairs or maintenance was required, that requests were appropriately actioned and they are very happy with their environment. Results of the most recent residents’ survey showed that out of eight surveys sent, seven residents thought the rest home was well maintained. Residents acknowledged on interview that they felt free and safe to wander outside. There is shelter provided outside that will enable the residents to keep dry and out of the sun. Outside tiles recently had non-slip matting applied to provide extra safety as the non-slip coating applied to the tiles when laid was not effective enough in frost and snow conditions.Methven House supplies appropriate equipment, such as walking frames, to meet contractual requirements. |
| Standard 1.4.3: Toilet, Shower, And Bathing FacilitiesConsumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | There are adequate numbers of accessible bathroom and toilet facilities throughout the facility for residents, with separate staff and visitor facilities. Appropriately secured hand rails are provided in the toilet/shower areas, and other equipment/ accessories are available to promote resident independence. |
| Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.  | FA | All bedrooms are of a size which allows enough space for residents to mobilise with or without assistance or mobility aids in a safe manner. Bedrooms are personalised to meet resident’s wants and needs and have appropriate areas for residents to place personal belongings. Seven bedrooms are single occupancy and three are shared rooms of two beds. Access to the call bell system is available at each bed space and privacy curtains are in use. Currently one married couple share one of these rooms. The nurse manager confirmed that residents are informed prior to admission of whether single or double rooms are available. If they prefer a single but choose double in the interim, they are given first choice when a single room becomes vacant. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And DiningConsumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | Residents are provided with safe, adequate areas to meet their relaxation, activity and dining needs. Dining and lounge areas are separated. The areas are appropriately furnished to meet residents’ needs. Residents and family/whānau voiced their satisfaction with the environment. Activities are undertaken in one lounge as observed on the day of audit. Residents, unless unwell, eat in the dining room. Recently, all dining room chairs have been replaced to enable, where possible, the residents to move the chairs themselves, the new chairs being lighter and easier to manoeuvre. |
| Standard 1.4.6: Cleaning And Laundry ServicesConsumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | The service has documented procedures in place for cleaning and laundry tasks. Chemicals are stored securely with safety sheets available in close proximity to all chemicals. Cleaning is carried out by a designated person on the morning shift. The facility looks and smells clean.Time is allocated for caregivers to undertake laundry tasks throughout the day. These dual roles are identified in the caregivers’ job descriptions and staff confirmed they have time to complete all tasks. Staff understand what each wash cycle is for and when to use. Bed linen and towels are placed in a laundry bag and are laundered off site and a clean bag is collected at the same time. A dirty to clean process is used within the laundry and a line on the floor acts as a reminder to staff.Recent resident satisfaction survey stated seven out of seven residents thought the cleaning and the laundry services were very good. |
| Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations. | FA | Polices and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters. Methven House have developed clear processes should an event occur, including having a file stating which family/whanau could have their family member at home for a short period if the issue was related to Methven House. Meetings with local motel owners and community providers have occurred to enable plans for various emergency situations to be well documented, and enable Methven House and its residents to be supported. A register is in place to monitor each resident’s whereabouts at all times. All staff have a current first aid certificate which is renewed two yearly.The current fire evacuation plan was approved by the New Zealand Fire Service. A trial evacuation takes place at regular intervals (most recently November 2016) and particularly if a new resident moves in or a new staff member joins the staff. The local fire service has regular familiarisation visits at Methven House. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures. All resident areas have fitted smoke alarms and a sprinkler system which is checked monthly. Methven House is on the local council priority list for snow clearing.Adequate supplies for use in the event of a civil defence emergency, including food, water and gas bottle with cooker, are in place and emergency lighting is checked six monthly.Call bells alert staff to residents requiring assistance. At night, to reduce the sound level for the residents, one switch in the building is turned off, however the sound remains able to be heard by staff. Residents reported staff respond promptly to call bells.Security systems in place include staff checking that doors and windows are closed after dark. Staff and residents interviewed confirmed they feel safe at all times. Last year Methven House did have a breach in security where an unknown person came on site and scammed a resident. They took this very seriously and carried out a full investigation which then went to the management board. The family and resident were happy with the process. Police were notified and a section 31 was provided to the Ministry of Health and the local District Health Board (DHB). |
| Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | All residents’ rooms and communal areas are heated and ventilated appropriately. Rooms have natural light and opening external windows. All communal areas have heat pumps, which on the day of audit were on, and the facility was warm.  |
| Standard 3.1: Infection control managementThere is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.  | FA | The service provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a comprehensive and current infection control manual, with input from the NM and Infection Prevention and Control Officer (IPC). The infection control programme and manual are reviewed annually. A registered nurse is the designated IPC coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the NM, tabled at the monthly staff meetings and reported at the regular board meetings.Signage at the main entrance to the facility requests anyone who is unwell, or has been unwell in the past 48 hours, not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these related responsibilities. |
| Standard 3.2: Implementing the infection control programmeThere are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The infection prevention and control (IPC) co-ordinator has appropriate skills, knowledge and qualifications for the role, and has been in this role at Methven House for the previous two years and in a previous hospital as an IPC co-ordinator for five years. She has undertaken IPC training and attended relevant study days, as verified in training records sighted. Well-established local networks with the infection control nurse specialist, Older Persons’ Health, are available and expert advice from the laboratory is available if additional support/information is required. The IPC co-ordinator has access to residents’ records and diagnostic results to ensure timely treatment and resolution of any infections.The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection. There has not been an outbreak in the previous ten years. |
| Standard 3.3: Policies and proceduresDocumented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies are reviewed yearly and include appropriate referencing.Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices. |
| Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | Priorities for staff education are outlined in the infection control programme annual plan. Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by a suitably qualified registered nurse/ infection control co-ordinator. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained.When an increase in infection incidence has occurred, there is evidence that additional staff education has been given.Education with residents is generally on a one-to-one basis and has included, reminders about handwashing, and advice about remaining in their room if they are unwell. Families confirmed they are given education if their family/whanau member is unwell. |
| Standard 3.5: SurveillanceSurveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. When an infection is identified, a record of this is documented in the individual infection register in the resident’s clinical record, infection reporting form, and resident management system. The infection control co-ordinator reviews all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Tables are produced that identify trends for the current year, and comparisons against previous years and this is reported to the Nurse Manager and the Board.New infections and any required management plans are discussed at handover, to ensure early intervention occurs. Surveillance results are then shared with staff at the staff meetings, as confirmed in meeting minutes sighted and interviews with staff.  |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator is available to provide support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation’s policies, procedures and practice and her role and responsibilities. On the day of audit, no residents were using restraints and no residents were using enablers. There have been no restraint events used for the past four years. Restraint training and education is a component of the orientation package and all staff files reviewed had evidence of this being completed. |

# Specific results for criterion where corrective actions are required

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

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

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

|  |
| --- |
| No data to display |

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

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

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

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

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| Criterion 1.2.3.9Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;(b) A process that addresses/treats the risks associated with service provision is developed and implemented. | CI | Data from incident reports showed that the local fire brigade had been called to assist staff in assisting residents to their feet or onto a bed, this process aligned with policy. Staff injuries as well as residents’ falls were analysed. Discussion with a hoist manufacturer occurred and two different hoists were delivered and trialled. Education sessions on the use of the hoist were given. A related competency was also developed at this time. During the trial period, all staff and residents were included in the sessions on the use of the hoist and residents feedback was taken, especially their views on how comfortable they found the hoist and how safe they felt. Staff feedback was also seen as important, particularly those caregivers who worked alone. A hoist selection was made and a proposal sent to the board for funds. A hoist was bought and since purchasing a review has been undertaken. It has been used five times since being purchased to assist residents to get up off the floor, all have been unable to move themselves or with the help of caregivers. One of these occasions was following a resident suffering a cardiac arrest in the chair, and unconscious, the use of the hoist enabled the staff to return the resident to her bed with dignity intact and with no wait time whilst the fire brigade arrived. Residents and staff report that the hoist was easy and safe to use and Methven House have not had to use the volunteer fire brigade to move the residents. Regular practice using the hoist occurs and a policy is now in place to support its use.  | Methven House had a no lift policy for a weight greater than 16kg. The policy regarding how to move a resident who was unable to get off the ground by themselves, highlighted that the current policy and process was inadequate and not ideal. The local fire brigade were used but this was thought to be no longer sustainable and had the potential to be expensive. Staff and residents were also at risk of injury. A decision was made to purchase a hoist. Since its purchase a year ago there have been no fire brigade call outs and residents have successfully been lifted from the floor. |

End of the report.