

Methven Aged Person's Welfare Association Incorporated - Methven House

Introduction

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

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

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

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

The specifics of this audit included:

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: 25 September 2018 End date: 25 September 2018
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:	13

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Methven Aged Person's Welfare Association Incorporated (Methven House) is a small rest home facility for up to 14 residents in mid-Canterbury. It is owned by the people of Methven and administered by a committee of community members. The facility is managed by a nurse manager with assistance from a registered nurse. An additional resident's room that is suitable for the purpose has become available since the last audit. Residents and families spoke positively about the care provided.

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

There were no areas identified as requiring improvement at the last audit; however, seven areas were identified as requiring improvement during this surveillance audit. These related to the need for review of the business plan, implementation of components of the quality system, review of the risk management plan, delivery of the staff training schedule, meeting interRAI competency expectations, additional staff resource for the activities programme, completion of medicine management competencies and for the menu to be reviewed to ensure the nutritional needs of residents are met.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to interpreting services should they be required.

Information about the complaints process is readily available. Staff and residents were aware of how to lodge a complaint. A complaints policy and a complaints register are in place.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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The scope, values and mission statement of the organisation are described in organisational documentation. Reports about the services provided are presented to the governing body each month. An experienced and suitably qualified person manages the facility.

The quality and risk management systems include the collection and analysis of quality improvement data, identifies trends and leads to follow up actions and improvements. Staff are involved, and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, have been identified. Policies and procedures are reviewed regularly and those sighted were current.

The appointment, orientation and management of staff are based on current good practice. A staff training schedule has been developed and individual performance reviews are completed. Staffing levels and skill mix meet the changing needs of residents.

Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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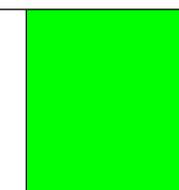
A registered nurse and general practitioner assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Short term care plans are implemented when indicated.

Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents and family members are consulted about the care provided and about any significant changes. The planned activity programme provides residents with a variety of activities they may choose to participate in.

A medicine management system is implemented as per the medicine management policies and procedures that meet legislative and sector requirements. There is a competency process in place for staff administering medicines.

Food is prepared in an on-site kitchen according to a flexible menu and personal preferences of residents. Special dietary needs are catered for according to requirements. Safe processes are in place for the storage, preparation and serving of food. Residents verified satisfaction with the meals and commented on enjoying the home-cooked nature of them.

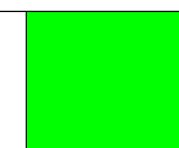
Safe and appropriate environment

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

A room previously used as an office has been converted into an additional resident's room. This meets requirements and is now in use.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Restraint minimisation policies and procedures are available. There are not currently any enablers or restraints in use at this facility. Staff were aware of the difference between a restraint and an enabler and what an enabler is used for.

Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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The infection prevention and control programme includes monthly aged care specific surveillance of the incidence of infections. Results are reported through all levels of the organisation. Relevant follow-up action is taken as and when required.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	10	0	3	3	0	0
Criteria	0	34	0	4	3	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaint policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is reportedly provided to residents and families on admission and those interviewed knew how to make a complaint and advised who they would go to. The nurse manager is responsible for follow-up and management of any complaints. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. Residents and family members informed they had been given information about how to make a complaint. Further reminder information about making a complaint is provided at the residents' meetings held three to four times a year and complaints forms were sighted near the front door of the facility.</p> <p>The complaints register showed that there has not been either a formal verbal or written complaint received since 2016. According to the nurse manager, any question raised that may indicate a person has a concern is actioned immediately. Previously recorded complaints on the register had been addressed and a resolution agreed to. There have been no complaints received from external sources since the previous audit.</p>
Standard 1.1.9: Communication	FA	Open disclosure is described in policies and procedures in a manner that meets the

<p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>requirements of the Code of Health and Disability Services Consumers' Rights (the Code). The manager and staff demonstrated their understanding of the principles of open disclosure. Residents and family members stated they were kept well informed about any changes to their/their relative's status. They are also advised about any incidents or accidents and outcomes of regular and any urgent medical reviews in a timely manner. This was supported in residents' records reviewed and in copies of completed adverse event reports.</p> <p>The manager and registered nurse confirmed they know how to access interpreter services through Ashburton Hospital. They reported there has not been the need to access this service and all current residents are fluent in English. Residents are assisted with hearing aids when required and this was observed during the audit.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>PA Low</p>	<p>The business plan is scheduled to be reviewed annually; however, this has not occurred since the 2016 – 2017 version and has been raised for corrective action. The 2016-2017 version was sighted and covered relevant goals and action plans. Methven House celebrated 40 years of existence in 2017 and at this time the mission statement was changed to 'Caring with compassion and dignity'. The philosophy and values recorded separately include concepts of maintaining residents' independence and outside links/contacts, culture consultations, staff responsibilities, safety, legislative requirements and best practices, for example. A sample of the nurse manager's monthly reports to the committee was sighted and showed that appropriate information is being provided to assist the committee to monitor performance.</p> <p>Methven House is managed by a nurse manager, with assistance from a registered nurse, who deputises in her absence. The nurse manager is also a registered nurse, has a current practising certificate, a degree in advanced nursing and is maintaining professional development through attendance at formal training and conference and seminar attendance. She is suitably experienced as has been in the role for nearly 12 years. Responsibilities and accountabilities are defined in a position description and an individual employment agreement. Knowledge of the sector, regulatory and reporting requirements was evident throughout the audit.</p> <p>The service holds contracts with the District Health Board to provide rest home care for up to 14 residents. Thirteen residents were receiving services under the Aged Related Residential Care Services Agreement contract at the time of audit. Four independent living units are on the same property as Methven House but were not included in this audit.</p>

<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>PA Moderate</p>	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of concerns and complaints, incidents, resident and family feedback, internal audits, health and safety and risk reviews and monitoring of outcomes. A quality policy statement notes that Methven House strives to improve care, people and processes and notes the service provider's commitment to quality whilst encouraging innovation, efficiency and productivity.</p> <p>Staff meetings are held every two months and the manager reports to the Methven Aged Person's Welfare Association committee meetings every month. Both sets of meetings were reported to be platforms for the discussion of quality and risk related issues. Meeting minutes reviewed confirmed review and analysis of quality indicators from various areas such as the environment, incidents, documentation and clinical care is occurring, and that related information is reported and discussed. Staff reported their involvement in quality and risk management activities by attending the meetings, signing they have read and understand new or changed policies and procedures, being aware of risks and co-operating with any changes the manager or registered nurse request. Residents contribute to meetings held approximately four monthly and they receive relevant information about quality improvement topics. Evidence available demonstrated that although many aspects of the quality management system, especially incident reporting, are being implemented as required, other areas have fallen behind over the last 10 to 12 months and this has been raised for corrective action. For example, corrective actions have been developed for previously completed internal audits, as per the system, but not all have been followed up in a timely manner; the annual resident and family satisfaction survey has not been distributed for the current year; not all the internal audits have been undertaken according to the scheduled timeframe and a six-monthly infection report is overdue.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements. These are based on best practice and were current following review in February 2018. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The nurse manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. A corrective action has been raised as the documented risk management plan has not been reviewed and evidence available suggested that only some of the components in the plan have been reviewed within the last two years. The manager is familiar with</p>
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		the Health and Safety at Work Act (2015) and has implemented requirements. Comprehensive health and safety related procedures are available.
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, open disclosure had occurred when relevant, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to both the staff meetings and the association committee meetings by the nurse manager. Specific reports for falls and medication errors/incidents were viewed.</p> <p>The nurse manager and the registered nurse, who often deputises, described essential notification reporting requirements, including for pressure injuries. They advised there has not been any significant event that required notification to the Ministry of Health or other regulatory authority, since the previous audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	PA Moderate	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required.</p> <p>Evidence of professional qualifications having been validated for the current year for registered nurses, including the district nurse, the attending GPs, podiatrist and a visiting physiotherapist were viewed.</p> <p>A new staff orientation programme is documented in policies and procedures. Staff orientation includes all necessary components relevant to the role. Interviewees reported that the orientation process is adequate to prepare new staff for their role. Staff records reviewed show documentation of completed orientation checklists.</p> <p>Continuing education, which includes mandatory requirements, is planned on an annual basis. All except the two newest staff have completed a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. The nurse manager is maintaining her annual competency requirements to undertake interRAI assessments and is currently responsible for them all because the registered nurse no longer has competency in this area. As the training schedule has not been able to be implemented as planned, not all staff have completed some key required topics, and this has been</p>

		raised for corrective action. Records reviewed demonstrated completion of annual performance appraisals.
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>A good employer policy and procedure was being implemented. This document determines staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The nurse manager, or registered nurse, is responsible for adjusting staffing levels to meet the changing needs of residents and examples of this having occurred were discussed. Caregivers may take on dual roles such as caregiving and cook, caregiving and activities or caregiving and cleaning. Different aprons demonstrate the role of the person at a given point in time. An after-hours on call roster for the nurse manager and/or registered nurse to provide additional advice and assistance is in place and review of the rosters for the past eight weeks showed that all shifts had been filled. The person on afternoon shift who is allocated the eight-hour shift is the person in charge. The nurse manager is maintaining her interRAI assessment skills and is currently undertaking all resident assessment, reassessment and interRAI generated care planning. As noted for corrective action in 1.2.7.5, the interRAI competency of the registered nurse has lapsed.</p> <p>Staff reported that good access to advice is available when needed. Caregivers reported that although the residents require more care than they did in the past and there is no longer the time to stop and do one on one activities with the residents, adequate staff are available to complete the residents' care and support tasks allocated to them. Residents and family interviewed supported this, although commented that residents seem to have more down time and there are fewer activities than previously (refer corrective action 1.3.7). All caregivers are required to have first aid training and to have a medicine management competency; although as noted in the corrective action under 1.2.7.5 some of these are overdue for renewal.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	PA Moderate	<p>The medication management policy is current and identifies all aspects of medicine management in line with legislative requirements and the Medicines Care Guide for Residential Aged Care.</p> <p>Observations of the midday medicine round showed staff awareness of requirements and safe practices. However, during the late afternoon a staff person was observed administering medicines in a manner that was not consistent with safe practice. All staff who administer medicines are required to complete an annual competency to perform the functions they manage. A corrective action has</p>

		<p>been raised as records sighted showed that only a third of the appropriate staff had completed these within the past year.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. A registered nurse checks all medicines against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided as required and is involved in all new and renewed prescriptions. When a medicine requires refrigeration, it is stored in a specific part of the kitchen fridge and records of temperatures for this fridge are monitored daily.</p> <p>Controlled drugs are stored in a locked cabinet although on the day of audit there were none in use. Two days before the audit the lock on this cabinet had malfunctioned. The manager had ordered a new cabinet which was due the day after the audit. Post audit, the nurse manager provided the auditor with a photograph of the newly secured cabinet. Two staff check all medicines with restrictions for accuracy when they are administered. The controlled drug register provided evidence of appropriate stock checks and accurate entries.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review is consistently recorded on the medicine chart. Standing orders are not used in this facility.</p> <p>There were no residents self-administering medications at the time of audit. One person holds a container of a medicine but requires staff assistance to administer it. Appropriate processes are in place to ensure self-medication is managed in a safe manner.</p> <p>An implemented adverse event process for comprehensive analysis of any medication errors was evident with comprehensive reports available.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>PA Low</p>	<p>Night staff undertake baking and some meal preparation. The meals are otherwise cooked and served by experienced cooks, one of whom does extra shifts during which she works as a caregiver. An awareness of infection prevention and control processes was expressed, and different aprons are used for the different roles. The current menu is based on a previously approved one; however, a corrective action has been raised as the changes have not been reviewed by a dietitian. 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 the cooks and accommodated in</p>

		<p>the daily meal plan.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, previous satisfaction surveys and resident meeting minutes. Residents' weights are monitored monthly. One resident had been reviewed by a dietitian and fortified drinks added to their food intake.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by Ministry of Primary Industry is valid until 1 June 2019. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cooks and some of the longer serving caregivers have completed safe food handling training.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>All residents and family members interviewed expressed gratitude for the care and support provided at Methven House and offered high praise for the staff. Documentation sighted, and observations made, verified the provision of care provided to residents was consistent with their needs, goals and their plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision.</p> <p>During interview with the GP, it was verified that medical input is sought in a timely manner, that medical orders are followed, and care is excellent. Community appreciation for the services provided at Methven House was noted and staff were acknowledged for providing a homelike environment. Care staff confirmed that care is provided as outlined in the service delivery plans and as requested by one or other of the registered nurses. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	PA Low	<p>The activities programme is provided by a trained diversional therapist who holds the national Certificate in Diversional Therapy. A personal profile of a social assessment and history is undertaken on admission to ascertain each resident's needs, interests, abilities and social requirements. Each resident also has an activity section within their care plan. Individual resident's activity needs are evaluated six-monthly as part of the formal care plan review.</p> <p>The overall activities programme on offer is diverse and includes a holistic range of options. Group activities are offered. According to the diversional therapist, review of the various activities provided occurs annually to help formulate an activity</p>

		<p>programme that is meaningful to the residents. Residents and families/whānau are involved in evaluating and improving the programme through feedback at residents' meetings and satisfaction surveys.</p> <p>Feedback from staff, residents and families, and details in records sighted, informed that not all residents have access to the available programme. All reiterated that despite the excellence of the diversional therapist, there are insufficient hours allocated for individual resident's needs to be met and a corrective action has been raised to address this.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident care is evaluated on each shift and reported in the progress notes. Any change noted is reported to one of the registered nurses.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care.</p> <p>Examples of short-term care plans being consistently reviewed, and of progress evaluated as clinically indicated, were noted. Infections, wounds, breakdowns in skin integrity and weight loss were all monitored and followed up. When necessary, and for unresolved problems, long term care plans are added to and updated.</p> <p>A multidisciplinary review is undertaken for each resident annually. Residents and families/whānau interviewed provided examples of involvement in their care and support and the review of their care, including management of any changes.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>Methven House is an older style facility that is appropriate and accessible for the residents. The facilities are fit for purpose and maintenance is being upheld. A current building warrant of fitness with an expiry date of 1 July 2019 was on display.</p> <p>Since the last audit an activity/sunroom area has been converted into an office and the manager's former office has been converted into a bedroom. The bedroom was viewed and observed to be of sufficient size and suitable for purpose. A wardrobe has been installed, new carpet laid, and a bed lamp affixed to the wall. During conversation, the current resident expressed her satisfaction with the room. A hand basin is in situ and a call bell system installed. The additional room has brought potential occupancy to 14 residents.</p>

<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal and the upper and lower respiratory tract. Policies and procedures described expectations for the infection surveillance process. All infections are reported on an infection report form and it is the role of the infection prevention and control coordinator, who is an experienced registered nurse, to review these. New infections and any required management plan are discussed at handover, to ensure early intervention occurs. Relevant documentation is made in a short-term care plan in the resident's file.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Efforts to identify trends for the current year have been made, as were comparisons against figures from previous years. Six monthly reports of this information have been developed and were sighted; however as identified in the corrective action for 1.2.3.5 the latest one (January 2018 – June 2018) has yet to be completed. Methven House does not currently have access to data from other services of similar size and type for benchmarking purposes, although efforts to access this information are being made. Results of the surveillance programme are shared with staff via the two monthly staff meetings.</p> <p>Several residents experienced short term gastrointestinal infection symptoms early 2017. The registered nurse discussed these with the local medical centre staff and they were included in the analysis of infections for that time period.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The nurse manager and registered nurse advised that staff undertake training on managing challenging behaviour and an example of a behaviour monitoring chart was sighted. Staff training records showed behaviour management training (October 2017) but there was no evidence of training specifically on the use of restraint or enablers (refer corrective action 1.2.7.5). However, during interview two of the staff were familiar with what an enabler is, compared with a restraint.</p> <p>On the day of audit, there were no residents using a restraint or an enabler and the manager advised that such equipment is not really required in this facility and would only be used as a last resort.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.1.1</p> <p>The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.</p>	PA Low	The mission, values and scope of the organisation are clearly stated in various organisational documents. Relevant organisational goals and detailed action plans in a 2016-2017 Business Plan cover topics of audit, administration, governance, staff, services, public relations/marketing, buildings, furnishing and equipment. These require review as many are no longer relevant or require amendment to reflect the current situation(s) at Methven House.	The goals and action plans in a 2016-2017 business plan have not been reviewed and therefore do not reflect all current aspects of the operations of the service.	<p>The goals and action plans of the organisation within the business plan require updating to reflect current intentions and operations of the service.</p> <p>180 days</p>
<p>Criterion 1.2.3.5</p> <p>Key components of service delivery shall be explicitly linked to the quality management system.</p>	PA Low	Key components of service delivery sit within the documented quality and risk system and efforts to ensure implementation of the system were evident. However, not all aspects have been undertaken within the timeframes detailed on the quality plan. The manager	Components of the quality management system, including internal audits, corrective action follow-up, an infection report and family and resident surveys have not been fully implemented, or reviewed, within expected	All aspects of the quality management system, including those related to service delivery, shall be implemented according to the documented

		and registered nurse explained that increased acuity of the residents' needs over several months; a period of absence by the nurse manager due to compromised health and unexpected staff resignations had contributed to this problem. Examples of the shortcomings are as follows: the registered nurse had tried to prioritise, but not all internal audits have been completed according to the schedule; corrective actions of completed audits, and other aspects of the quality system had been developed; however, these have not all been followed up within expected timeframes. The resident and family surveys due February 2018 have not been undertaken and a six-monthly infection control report for January to June 2018 has not been completed.	timeframes.	timeframes. 180 days
<p>Criterion 1.2.3.9</p> <p>Actual 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:</p> <p>(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;</p> <p>(b) A process that addresses/treats the risks associated with service</p>	<p>PA Moderate</p>	<p>A comprehensive risk management plan that includes organisational and service delivery risks is in place. The risk management plan has not been reviewed since the 2016 version was signed off. Within the plan, risks have been identified under a range of categories, with associated ratings for their level of risk, strategies for mitigating the risk as well as timeframes for their review. A range of strategies to review the different risks vary from staff performance appraisals to internal audits and infection surveillance were described in the plan. Because these monitoring strategies have not all been implemented, components of the risk management plan have also not been reviewed within the required timeframes.</p>	<p>A risk management plan is in place; however, neither the plan, nor many of its components have been fully reviewed within the last 18 months.</p>	<p>The risk management plan and all identified risks are monitored, evaluated and reviewed within timeframes commensurate with the level of risk.</p> <p>90 days</p>

<p>provision is developed and implemented.</p>		<p>Organisational risks associated with service delivery are included in the risk management plan, although risks identified for individuals are detailed in each resident's care plan. The latter are reviewed six monthly, or earlier if indicated.</p>		
<p>Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	<p>PA Moderate</p>	<p>Schedules of staff training topics for each year from 2015 to 2018 were sighted. In addition to mandatory topics, special interest topics such as diabetes had been included. Only four of the scheduled topics had been delivered since October 2017. In addition, there were overdue medication competencies (refer corrective action 1.3.12.3) and not all staff had current first aid certificates. Records of staff attendance at training sessions were reviewed in the sample of staff files and showed attendance had tapered off since late 2017. Staff informed during interview that staff training is usually provided following the staff meetings held every two months, but these had been less frequent of late due to additional demands on their time. Staff interviewed said they had finished their national certificates and informed that the nurse manager was always very good at allowing them to attend suitable external training opportunities. Although the registered nurse, who is also responsible for care planning and reviews, has completed interRAI training, her competency in this area has lapsed. This has been added to the corrective action as there is otherwise only the manager with a current interRAI competency and</p>	<p>Not all staff training topics have been delivered according to the schedule; therefore, not all staff have received training on some key mandatory topics such as emergency management, safe food handling or restraint use, for more than two years. The interRAI competency of the registered nurse has lapsed.</p>	<p>Service providers are required to complete mandatory training requirements to ensure service delivery to residents is safe and effective. Adequate numbers of staff with a current interRAI competency are required.</p> <p>180 days</p>

		ongoing maintenance of the care plans and reviews are dependent on her being available.		
<p>Criterion 1.3.12.3</p> <p>Service providers responsible for medicine management are competent to perform the function for each stage they manage.</p>	<p>PA Moderate</p>	<p>During the audit, a lack of competency by a caregiver in relation to medicine administration was observed. The incident was discussed with relevant personnel.</p> <p>As per policy documents, a medicine management competency system is in place and all registered nurses and caregivers are required to redo this annually; except for casual staff who only complete a medicine checker competency. The process involves each staff person to provide written responses to questions as well as undergo an observed medicine administration round. One of the registered nurses oversees these processes. Records show that all staff, except two new ones who are not yet administering medicines, have previously completed a medicine competency. However only three of the nine staff expected to have a full medicine management competency have completed one within the past 12 months. To ensure this is actioned promptly, a short response timeframe has been allocated.</p>	<p>An example of medicine administration not consistent with accepted medication administration competency was observed during the audit. Six of nine staff who require a medicine administration competency have not completed this within the past twelve months.</p>	<p>All service providers responsible for any aspect of medicine management have completed a relevant medicine management competency within the past twelve months.</p> <p>30 days</p>
<p>Criterion 1.3.13.1</p> <p>Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines</p>	<p>PA Low</p>	<p>Most of the meals are based on a menu that was approved by a dietitian in 2015, although several changes have since occurred. The menu is often influenced by seasonal fruit, vegetables and produce provided by local citizens. A corrective</p>	<p>The menu in use has not been reviewed by an appropriate registered professional to confirm the nutritional needs of the residents are being met.</p>	<p>A relevant registered health professional reviews the menu to ensure the food, fluid, and nutritional needs of consumers are provided in line with recognised</p>

appropriate to the consumer group.		action has been raised for the menu to be reviewed by a relevant health professional to ensure it meets the nutritional needs of the older person. Records have been commenced to note deviations from the menu and the information will contribute to the new menu.		nutritional guidelines appropriate for older people. 180 days
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	PA Low	<p>A diverse activity programme prepared by the diversional therapist each month is in place. However, only six hours a week and some volunteer hours are allocated to implement the programme. The diversional therapist, other staff, residents and family members interviewed all commented that residents' abilities have reduced, and they can no longer occupy themselves as they once could, nor take themselves to the village. Some residents now have significant hearing and visual impairments, which means they can no longer easily participate in group activities, but there is insufficient time for one on one individual sessions with them. The acuity of residents' needs has increased and caregiving staff who once assisted with activities, especially individual ones, informed they no longer have this time. Residents and family members noted that residents are less well occupied than previously and on the day of audit there was limited evidence of resident engagement in diversional activities. Activity support plans are being completed; however, personal goals are not able to be achieved due to limited resource to implement residents'</p>	<p>There are minimal staff hours and limited staff resource dedicated to the activity programme. This is restricting community-based activities and is not enabling individual programmes to be fully implemented, nor individual activities to be provided, as required in clause 16.5 (c) (iii) and 16.5 (d) of the contract.</p>	<p>The residents' activity programme enables strong links with the community and meaningful individual activities to be pursued.</p> <p>180 days</p>

		individual action plans.		
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.