

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: 23 September 2021 End date: 23 September 2021

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

Indicator	Description	Definition
Yellow	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
Red	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 is a community owned and operated residential facility in a rural setting in Mid-Canterbury, providing rest home level care for up to fourteen residents. The incorporated society (committee), which operates the facility, has representative and elected membership from within the local community. A nurse manager oversees a small care team. Residents and families felt well supported by the care team and were well satisfied with the service.

This surveillance audit was undertaken against the Health and Disability Services Standards (2008) and the service's contract with 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, management, staff, and a general practitioner.

Four areas for improvement were identified during this audit. Two remain work in progress from the previous audit in relation to corrective action planning and evaluation of care plans. Two new areas for improvement were identified related to risk management and reporting and analysis of key indicators.

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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Communication is regular and open between staff, residents, and families. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent, and this is documented.

Complaints management is described in accordance with the Code, although no resident related complaints had been raised since the previous audit.

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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Methven Aged Persons Welfare Association Incorporated (MAPWAI) has a current strategic and business plan which includes the mission, philosophy, and objectives of the organisation. The governing committee is responsible for governance and the nurse manager has day to day operational responsibilities for the service. A monthly report is provided to the committee. An assistant nurse manager has recently been appointed to assist the nurse manager in operational aspects of the service.

Quality data relating to key performance indicators and resident and family feedback is collected and reported. An internal audit system is used to monitor operational performance and is planned annually. Hazards and health and safety issues are documented and mitigated. Adverse events including accidents and incidents are routinely documented. A suite of policies and procedures were up to date.

The processes around the appointment, orientation and management of staff are based on current accepted good practice. Staff education is regularly provided for all staff groups, with regular attendance noted. Performance reviews are up to date and occur after three months employment and then annually.

Staffing levels and the skill mix are suited to the needs of residents. Rosters reviewed confirmed that contractual requirements are being met.

Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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Residents are assessed on admission and their needs documented within the required timeframes. Staff hand over between shifts and document any changes to ensure continuity of care.

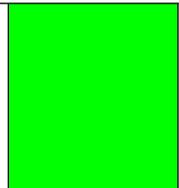
Care plans are developed and individualised, based on the interRAI assessment and any identified deficits. A short-term care plan is developed to plan and manage any new problems that arise. These are routinely used. Residents' needs, personal goals and expected outcomes are documented and responses reviewed. Families are frequently involved with their family member and their care. The local medical practice supports resident's medical care and visits are made appropriately when a resident's condition

changes. An activities coordinator implements group and one on one activities suited to resident's interests and the rural community environment.

Medicines are managed according to policies and procedures based on current good practice. Medication is administered using an electronic system by staff who have been assessed as competent to do so.

The food service has a verified food control plan. Residents and family members expressed overall satisfaction with the quality and quantity of meals provided.

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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Methven House has a current building warrant of fitness. Staff are trained in emergency procedures, fire evacuation and first aid.

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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Methven House is restraint free and there were currently no enablers used by residents. Policies are in place to guide restraint use should it be needed.

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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Infection surveillance is undertaken and reported as outlined in the infection control policy. There are low infection rates reported.

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	14	0	1	1	0	0
Criteria	0	35	0	3	1	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>Two residents interviewed were aware of how they can raise any concerns, including at resident meetings and through the satisfaction survey. Staff stated that resident preference is to raise concerns informally. None have ever made a written complaint. There were no resident related complaints documented on the complaints register since 2019. A current policy guides management of any complaint. There is a detailed complaints form, which includes availability of advocacy and time frames for responses in accordance with the Code of Health and Disability Services Consumers' Rights (the Code). Compliments made to the service and/or individuals is communicated to staff at meetings. The register is up to date which addresses a previous improvement request.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective</p>	FA	<p>Methven House has an open disclosure policy which is implemented should a resident experience an adverse event. Actions taken are recorded on the incident form. There have not been any events requiring open disclosure since the previous audit. GP notes reviewed indicated effective communication and discussion with the resident where treatment options are presented for consideration.</p> <p>Residents interviewed described how they can openly communicate and express any concerns to staff and management. It was observed that staff approached residents in an unhurried manner and took time to listen to their needs. A family member interviewed felt comfortable raising any concerns with staff, which were always addressed as far as possible.</p>

communication.		Interpreting services can be contacted, although there have been no requirements to do so.
<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>	FA	<p>A new committee chair has recently been appointed, with the goal of leading the organisation through to the next stage, with a proposal to raise community funds for a new facility. The committee is yet to develop a comprehensive risk management plan, and this is an area for further development (refer also 1.2.3.9). Organisational values have remained focussed on maintaining a home-like environment where freedom of choice can be maximised, and people can age safely within their own community.</p> <p>The current nurse manager was appointed in 2019, having previously worked in a variety of primary and secondary care roles. She has undertaken several external courses focussed on leadership and management in the aged care sector. This includes an Eight Step Leadership Programme in 2020, which addresses a previous corrective action. She continues to undertake suitable professional development to maintain competency in aged care.</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>	PA Moderate	<p>The organisation has an implemented quality system that reflects the principles of continuous improvement and is understood by staff. It includes management of adverse events, such as medication errors, complaints, audit activities, staff and resident/patient satisfaction survey and monitoring of indicators, such as pressure injuries, infections and falls.</p> <p>Staff meeting minutes reviewed confirmed adequate reporting processes. This forum enables discussion on quality matters and opportunities for improvement. There is a focus on improvement, particularly where it relates to clinical care. However, quality data needs further analysis. Most data remain in its raw form and trending over time is not explicitly undertaken. Data collected is reported and discussed at the bimonthly staff team meeting which incorporated feedback on quality activities. Graphs are included for data that is presented to the committee. There is discussion on any relevant clinical indicators, such as pressure injuries, falls, complaints, incidents/events, and infections. Education sessions occur in the months between meetings, with a comprehensive programme in place. Staff contribute to quality and risk activities through participation in audit activities. Adverse events are reported, however corrective actions, where required, remain an informal process (see 1.2.3.8).</p> <p>Resident and family surveys are completed annually including a recent survey. Analysis of the 2021 resident survey indicates a high level of satisfaction and improving satisfaction with the environment and outdoor areas.</p> <p>An annual internal audit schedule is implemented, with all key areas monitored for performance. Results are discussed at staff meetings where deficits are identified. Improvements in the past year have included the introduction of an electronic medication system, handover sheets and equipment purchases.</p> <p>Policies reviewed covered all necessary aspects of the service and contractual requirements and were current.</p>

		<p>Staff are updated on new or changed policies at the staff meetings.</p> <p>The nurse manager described the processes for the identification, monitoring and reporting of hazards which are reported through the event reporting process. Broader organisational risks are not identified either in a register or other appropriate document. Reporting and discussion about the likelihood and consequence of broader organisational risks does not feature in the committee and/or meeting structures. This is an area for improvement. Health and safety meetings have lapsed in recent times and ways to better engage staff are being sought.</p>
<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 hard copy accident/incident forms. A sample of incidents forms reviewed showed these are fully completed, incidents are investigated, action plans developed and followed-up in a timely manner by the nurse manager. Adverse event data is collated and reported at the staff meeting and in summary form to the committee. Meeting minutes sighted showed discussion in relation to follow up, action planning and improvement required, such as resident falls.</p> <p>Policy and procedures described essential notification reporting requirements (e.g., pressure injuries, health and safety, infection control, the coroner, professional bodies, Ministry of Health). The nurse manager advised there have been no essential notifications of significant events made 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>	FA	<p>Human resources management is guided by policies and procedures which are consistent with good employment practices and legislative requirements. Role descriptions define the tasks and accountabilities for the various roles. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. Staffing at Methven House is presently stable, following a challenging period with vacancies. A new assistant manager has commenced within the past three months and a permanent night staff vacancy has also been filled. A sample of five staff records were reviewed for various clinical and non-clinical roles. These were well organised and contained all relevant documents and a completed orientation for recent appointments. Staff orientation includes all necessary components relevant to the role.</p> <p>Verification of professional qualifications and annual practising certificates were sighted for a registered and enrolled nurse and the nurse manager. Records of New Zealand Qualification Authority qualifications for care staff were evident for staff achieving level three qualifications. Staff responsible for food services have completed recent updates on food safety. Annual performance appraisals have been completed for most staff who have been employed for more than one year. Four are just overdue. This is an opportunity to discuss individual training</p>

		<p>needs, and review competencies. Medication competencies and first aid were current for care staff.</p> <p>Staff stated that the education provided was relevant, varied and interesting. In-service training is frequent and appropriate to their needs, and they are encouraged to attend sessions. Education is planned on an annual basis, with the training schedule displayed for 2021. Internal and external speakers are accessed for sessions. Mandatory training requirements are defined and scheduled to occur over the course of the year. Completion is recorded on a spreadsheet and certificates held in individual files.</p>
<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>There is a documented rationale for determining staffing levels and skill mix to deliver safe resident care. These levels have been maintained for several years. The service operates a two-week roster cycle which is maintained at the base level even when occupancy varies. The nurse manager is on site five days per week and is supported by the part time assistant nurse manager who works three days each week. There is no nursing bureau available for back up, so the roster is invariably filled internally. Inspection of the last four weeks of the roster indicated that shifts are filled and there were no examples where the facility had “worked short”. The minimum number of staff occurs overnight, with one senior care staff member on duty. Back up is available by the on-call staff. Call is shared between the registered staff and, on occasion, by a member of the committee who has a health background.</p> <p>Domestic staff cover the household duties. Short shifts provide additional support over busy periods. An activities coordinator is available ten hours during the week. Observations and review of the roster cycle sampled during this audit confirmed adequate staff cover has been provided. Existing staff have flexibility to cover for short notice roster gaps and this was verified in the roster samples reviewed. All care staff hold a current first aid certificate, Care staff reported adequate staff were available and that they were able to complete the work allocated to them while providing person centred care. This was also supported by residents and family members interviewed, who reported that staff always made time for them, and they did not feel rushed when receiving care.</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>	FA	<p>A current medication management policy was current, referenced the Medicines Care Guide for Residential Aged Care and guides practice. Since the previous audit, the service has adopted an electronic medication management system.</p> <p>A safe system for medicine management 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. Annual competency assessments were on file and up to date. The facility has a blister pack system supplied by the local pharmacy for all residents requiring medication assistance. There is a reconciliation process implemented and documented electronically. Medications are supplied to the facility in a pre-packaged format from the local</p>

		<p>pharmacy. Staff were observed to check the blister against the prescription and follow the '5 + 3 Rs' of administration, including hand hygiene requirements. All medications sighted were within current use by dates.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy in administration. There is a double checker competency implemented for the second checker. The controlled drug register provided evidence of accurate entries and correct balances. Controlled drugs are blister packed where appropriate.</p> <p>Any medicines requiring refrigeration are stored separately in the kitchen fridge (there were no such medicines on the day of audit). The fridge is monitored, with records indicating temperatures are in the expected range. There is very limited use of pro re nata (PRN) medicines. The required three-monthly GP review is consistently recorded on the medicine chart.</p> <p>There were two residents who self-administer an inhaler at the time of audit. Appropriate processes were in place to ensure this is managed in a safe manner.</p> <p>Medication errors are reported to the nurse manager or registered nurse and recorded on an accident/incident form. The resident and/or the designated representative are advised. Any medication errors are reported and discussed at the staff meeting and to the committee as part of summary reporting. There have been no medication errors reported for several months.</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>FA</p>	<p>The food service is provided on site by a trained cook supported by care staff, who also provide the meals on wheels service in the district. The menu is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and is based on the University of Otago menu guides. It was reviewed by a qualified dietitian in 2018, with no recommendations made at that time. The service is progressing with the next dietician review, potentially to occur via a virtual link. The food control certificate was current until December 2021.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, and disposal comply with current legislation and guidelines, including monitoring of delivery temperatures of chilled and frozen items on delivery. Changes made to the standard menu are consistently recorded. Food temperatures, including for high-risk items, are monitored appropriately and recorded. The cook updated their safe food handling qualification in 2020. Care staff are responsible for reheating previously prepared meals for the light evening meal. Six staff have undertaken food safety training.</p> <p>A nutritional assessment is undertaken for each resident on admission as part of the long-term care plan development. Any personal food preferences, portion sizing, special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan as required. Special equipment, to meet resident's nutritional needs, is available if required. Currently, residents who are able to stand on floor scales have regular weight monitoring undertaken, however, weight monitoring for more frail residents cannot be completed as</p>

		<p>the weights recorded are not reliable. On the day of audit, the committee approved the purchase for suitable chair scales for this purpose.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and residents' meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Documentation, observations, and interviews verified the provision of care to residents was consistent with their assessed 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 the records sighted. The GP interviewed expressed confidence in the service and verified that medical input was sought in a timely manner, medical orders were followed, and care is appropriate and timely. They also reported that the facility and practice have refined the system to ensure a suitable response to emails and phone calls is initiated. Residents may visit the practice or receive a home visit.</p> <p>Care staff confirmed that care was provided as outlined in the documentation. They confirmed that ready access to registered nursing staff ensures they are well supported in care delivery. A range of equipment and resources is 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>	FA	<p>Planned activities are provided and facilitated by an activities coordinator. Ten hours are allocated over the week and are dedicated specifically to the activities programme; however, all staff participate in ensuring that residents are supported in activities which are meaningful to them. This may involve one-on-one engagement. Input from the local community occurs including a small group of volunteers, and occasional outings using a community van. There is regular community engagement including visits from the local library. Family outings also feature for some residents.</p> <p>A social assessment and history are undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are reviewed to help formulate an activities programme that is meaningful to the residents. The residents' activity needs are evaluated three monthly and as part of the formal six-monthly care plan review, although some were noted as overdue for review (Refer 1.3.8.2). Progress notes are maintained as part of the integrated file.</p> <p>The planned activities programme sighted matched the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents' goals, ordinary patterns of life and included normal community activities. On the day of the unannounced audit, a celebration was held with a morning tea to promote Alzheimer's Day. Residents spoken to say they participate in things they enjoy at group and individual level, but they are not forced to join in. Resident and family satisfaction surveys demonstrated satisfaction with the programme and that</p>

		information is used to improve the range and type of activities offered.
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	PA Low	<p>Formal care plan evaluations, occur every six months in conjunction with the six-monthly interRAI reassessment or as residents' needs change. In the files reviewed, these updates are yet to be incorporated into the plan of care. Evaluations are documented by the registered nurse. Where progress is different from expected, the service responds by making changes to the plan of care with a short-term plan initiated or with manual entries on the care plan to reflect changing needs. Examples of short-term care plans were on file for three residents.</p> <p>Resident care is noted on each shift and reported in the progress notes and the recently implemented handover sheet. If any change is noted, it is reported to the RN who updates the plan as necessary. Other plans, such as wound management plans are reported to be evaluated each time the dressing is changed, however evaluation of progress towards wound healing was not always evident on the wound care form (see 1.3.8.2).</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>A current building warrant of fitness (expires July 2022) was publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose. Methven House is an older building and there have been ongoing challenges in maintaining it. Interview with the committee chair confirmed essential maintenance has been completed including roof repairs to ensure weatherproofing. There is a reactive maintenance programme and buildings, plant and equipment are maintained to an adequate standard. Committee members and interested members of the community also help maintain the facility and its gardens. Local external contractors are used where required. The testing and tagging of equipment and calibration of bio medical equipment has recently been completed.</p> <p>External areas are safely maintained and are appropriate to the resident group. The outdoor area has flat access and was seen to be safely navigated by 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</p>	FA	<p>Surveillance is appropriate to that recommended for long term care facilities and the size and complexity of the organisation, and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. Infection control oversight is now the responsibility of the assistant nurse manager. Suitable training is currently being sought for upskilling in infection prevention and control best practice.</p> <p>Infections are documented in residents' progress notes; however, this system needs strengthening to ensure actual or potential infections are not missed when being reporting (see 1.2.3.5). Any new infections and treatment required is discussed at handover, to ensure early intervention occurs. Monthly surveillance data in raw form is collated and trends noted. There are very low rates of infections identified, mainly related to urinary infections. Results of surveillance is shared with staff via regular staff meetings and at staff handovers. Graphs track any</p>

infection control programme.		reported infections. Comparisons are made against previous year data, but at this point there is no benchmarking undertaken. Anonymised data is made available each month as part of regular reporting to the committee.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	<p>Methven House has policies and procedures for restraint and enabler use which can be implemented should the need arise. The service has been restraint free for several years. At the time of audit, there were no enablers in use.</p> <p>Restraint is an agenda item at the staff meeting each month. These minutes are available to the committee at their monthly meeting but quality indicators including restraint is not part of the regular agenda. (See also 1.2.3.5). Minutes reviewed confirmed that no restraint is being used. Training records sighted confirm that restraint minimisation training has recently been completed for staff. Challenging behaviour is well managed by staff.</p> <p>The restraint coordinator is a registered nurse who is familiar with the requirements of the standard.</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 1.2.3.5</p> <p>Key components of service delivery shall be explicitly linked to the quality management system.</p>	PA Low	<p>Key clinical indicators (KPIs) are collected each month, and are reported through the staff and management meetings to the governance committee. A close working relationship allows for frequent informal discussion and updates between the nurse manager and the governance committee chairperson. Analysis of data is often informal (e.g., trends are discussed but not always documented within the current systems). Data is graphed for the committee as a visual summary of performance.</p> <p>A data error was noted in relation to recorded infections – the summary report shows no infections had occurred in the previous nine months, however, review of a sample resident record indicates that an infection had occurred and been treated. The</p>	<p>KPI data is reported within the committee structure – this includes incidents, accidents and complaints, infection control and health and safety. Further development, including inclusion of all required indicators and improved accuracy of data will improve the usefulness of the</p>	<p>Develop and implement a system which enables consistent, accurate collection, analysis and reporting relevant key performance indicators</p> <p>180 days</p>

		<p>system to capture actual and potential infections needs further development to ensure all infections are consistently captured and reported.</p> <p>Restraint is not used at Methven House and presently, there are no enablers in use. This indicator is not formally reported within the quality system and committee structure as required by the standard.</p>	indicators.	
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	PA Low	<p>At the previous audit, outcomes of interventions for corrective actions were not always being documented and there was a lack of evaluation of the effectiveness of the interventions within the plans of care. Since the certification audit, examples of quality improvement activity are occurring, with some examples discussed.</p> <p>Internal audits are undertaken and, where shortfalls are identified, these are discussed at staff meetings. Follow up does occur, however the quality circle to demonstrate that actions taken have addressed the shortfalls is not recorded. Corrective action planning remains informal, and actions taken could not be evidenced to demonstrate compliance with this criterion. The previous corrective action remains open.</p>	Corrective action planning remains informal and the processes to recognise the need for and implement corrective actions is not reliably occurring.	<p>Implement clear, consistent processes for corrective action planning and evaluate its effectiveness.</p> <p>180 days</p>
<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: (a) Identified risks are monitored, analysed,</p>	PA Moderate	Actual and potential risks are identified and documented in relation to hazards and health and safety. However, there are gaps in aspects of the risk management system. There is no organisational risk register or equivalent document which identified key risks for the organisation. Aside from new hazards and any health and safety incidents, there is no evidence of a formal process to identify and	The current risk management system is incomplete and requires further development to ensure all organisational risks are identified,	Develop an effective risk management system which ensures all organisational risks are identified,

<p>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.</p>		<p>manage risks in the organisation. The governing committee has not identified or reviewed any changes in organisational risks. Quality and risk are not explicit agenda items at the governance committee meeting, to provide a formal mechanism and forum for discussion about pertinent risks.</p> <p>Hazards and health and safety issues are reported, and actions taken where required, however other risk management components do not demonstrate ongoing review and evaluation at a frequency which reflects the severity of the risk (i.e., higher rated risks being reviewed more frequently). Health and safety meetings with staff involvement have lapsed over recent months.</p>	<p>managed and reviewed.</p>	<p>managed and reviewed.</p> <p>90 days</p>
<p>Criterion 1.3.8.2 Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.</p>	<p>PA Low</p>	<p>At the previous audit, formal evaluations of care plans could not be evidenced in the files reviewed. The interventions were not consistently updated to reflect the current needs of the resident. At this surveillance audit, care plans are based on interRAI assessments and any identified deficits. A recent lag in updating the interRAI assessments has been addressed in that the reassessments are now up to date; however, care plans do not yet reflect the changes identified from the recently updated assessment. The nurse manager reports this update of plans has commenced. Increased nursing resource now available will support this.</p> <p>At this surveillance, evaluations are not fully completed or documented (e.g., Progress in wound healing is not being captured on the wound care form for two residents and it is difficult to determine the progress towards healing from the documentation reviewed (progress notes and notebook), which primarily identifies the interventions and products used. Resident documentation in</p>	<p>Effective evaluation is not yet consistently implemented for all aspects of care.</p>	<p>Implement and document regular evaluation of all aspects of resident's care plans.</p> <p>180 days</p>

		<p>relation to a recently healed wound does not demonstrate ongoing evaluation is recorded.</p> <p>Evaluation of activity's plans was not up to date in two samples.</p> <p>This previous corrective action remains open.</p>		
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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.