Methven Aged Person's Welfare Association Incorporated - Methven House

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

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: 3 March 2020 End date: 3 March 2020

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

General overview of the audit

Methven House provides rest home level care for up to fourteen residents. The facility sits in the small rural town of Methven in mid-Canterbury near the base of Mt Hutt. Methven House is owned by the people of Methven and administered by a committee comprised of community members. The service is operated by a nurse manager and a registered nurse/assistant nurse manager, both of whom are new since the last audit. Residents and families expressed gratitude that they can remain in their local district and spoke positively about the services provided at Methven House.

This certification 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, a pharmacist and a general practitioner.

Four areas for improvement were identified during this audit. These relate to the need for a complaint register, for the nurse manager to undertake management training, the evaluation of implemented corrective actions, and the formal evaluation of resident's goals.

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.		Some standards applicable to this service partially attained and of low risk.

At Methven House residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Services are provided that support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner.

Open communication between staff, residents and families is promoted, and confirmed to be effective. 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.

Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. There was no evidence of abuse, neglect or discrimination.

The service has linkages with a range of specialist health care providers to support best practice and meet residents' needs.

Information about how to make a complaint was readily available. Complaints are being followed through to resolution promptly and effectively.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.

A business, quality and risk management plan includes the mission, philosophy and objectives of the organisation. Services are monitored via comprehensive reports from the nurse manager to the governing body each month. A registered nurse manages the facility with support from a committee.

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

The processes around the appointment, orientation and management of staff are based on current accepted good practice. A range of relevant staff education opportunities are provided, and these are being attended. Regular in-house training is scheduled for the coming year. Individual performance reviews are completed at three months for new staff and annually thereafter.

Staffing levels and the skill mix for each shift meet the changing needs of residents. Rosters confirmed that contractual requirements are being met.

Continuum of service delivery

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.		Some standards applicable to this service partially attained and of low risk.

The organisation works closely with the local Needs Assessment and Service Co-ordination Service, to ensure access to the facility is appropriate and efficiently managed. When a vacancy occurs, sufficient and relevant information is provided to the potential resident/family to facilitate the admission.

Residents' needs are assessed on admission within the required timeframes. Shift handovers and communication sheets guide continuity of care.

Care plans are individualised, based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that might arise. All residents' files reviewed demonstrated that needs, goals and expected outcomes are identified. Families interviewed reported being well informed and involved in care planning and that the care provided is of a high standard. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

The planned activity programme is overseen by a qualified diversional therapist and provides residents with a variety of individual and group activities and maintains their links with the community. A van is hired for outings when required.

Medicines are managed according to policies and procedures based on current good practice and consistently implemented using a manual system. Medications are administered by staff who have been assessed as competent to do so.

The food service is provided on site by two cooks. Residents/family members verified overall satisfaction with meals.

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.

Waste and hazardous substances are managed according to requirements. Staff use the protective equipment supplied.

The facility meets the needs of residents, was clean and well maintained. Residents described it as ‘homely’. There was a current building warrant of fitness. Electrical equipment is tested, and bio-medical calibration checks are undertaken, as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Chemicals, soiled linen and equipment are safely stored. Personal laundry is undertaken onsite and bed linen and towels laundered off site. Cleaning and laundry processes are evaluated for effectiveness.

Staff are trained in emergency procedures and the use of emergency equipment and supplies. Appropriate emergency supplies were available, and the contents were checked regularly. Fire evacuation procedures are practised six-monthly. Security is maintained.

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.

The organisation has implemented policies and procedures that support the minimisation of restraint and guide staff in the management of challenging behaviours. There was a no restraint policy at the facility and there were no enablers being used at the

time of the audit. Staff were aware that any use of enablers is voluntary for the safety of residents in response to individual requests.

Infection prevention and control

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

The infection prevention and control programme, led by the registered nurse, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with education sessions.

Aged care specific infection surveillance is undertaken, data is analysed, trended and benchmarked and results reported through quality meetings. 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	41	0	4	0	0	0
Criteria	0	89	0	4	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Methven House has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging residents' independence, providing options and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provided relevant guidance to staff. Clinical files reviewed showed that informed consent has been gained appropriately using the organisation's standard consent form including for treatment of care, the right to make choices, for sharing of medical information and gathering of information for interRAI. Advance care plans were sighted in the five files reviewed. Staff were observed to gain consent for day to day care.
Standard 1.1.11: Advocacy And	FA	On admission, the resident information pack includes pamphlets on the Code and the Nationwide Health and Disability Advocacy Service. Each room has a complaint form available and there is a box

Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.		for depositing these by the front door. Family members and residents interviewed shared that there was not a great need for complaint forms as all staff were approachable but that they were aware of their right for a support person and how to access this service.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	The diversional therapist confirmed that assistance is provided for residents to maintain links with the community for such things as hairdresser appointments, doctor visits and church attendance. Visiting hours at Methven House are unrestricted and family members spoken to said that they always felt welcome when visiting and that staff were available for communication of any concerns.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	PA Low	The complaints policy and procedures described various types of complaints that might be lodged. It included actions to be taken when a complaint is lodged, response timeframes that are consistent with the Code and how to access advocacy services. An associated complaint management flowchart and a complaints form were sighted. Information on the complaint process is provided to residents and families on admission and a laminated copy of the complaints process is in each resident's room. Residents interviewed were aware they could make a complaint and staff confirmed a sound understanding of the complaint process and what actions are required. No complaints have been received through the Health and Disability Commission. Three complaints have been lodged with the manager since the last audit. A folder containing information about the investigation and follow-up processes was reviewed. There was no complaint register and this has been raised for corrective action.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Residents and their family members reported during interviews they were made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and discussion with staff. The Code is displayed in the dining room together with information on advocacy services, how to make a complaint and feedback forms.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect	FA	Residents and their family members confirmed staff of Methven House considered each resident's dignity, privacy, sexuality, spirituality and choices. Staff understood the need to maintain privacy and were observed doing so throughout the audit, when attending to personal cares, ensuring resident information was held securely and privately, exchanging verbal information and during discussion with

Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.		families and the GP. There are three shared rooms and consent to share was sighted for those residing in them. Residents are encouraged to maintain their independence and were assisted to attend events in the community. Each resident's care plan included documentation related to the resident's abilities, and strategies to maximise independence. The review of residents' files confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan. Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for staff with ongoing annual training. Family interviewed stated they had never witnessed any abuse or neglect.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	There is one resident who identified as Māori. The care plan includes cultural values and beliefs supported by a Māori Health Plan with guidelines for providing culturally safe services for Māori residents. Residents' rights and responsibilities and a section on privacy are available in te reo Maori. The resident expressed satisfaction that care provided was appropriate. Biannual training occurs on cultural safety.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	Residents interviewed reported that during admission they were consulted on their individual values and beliefs and review of files confirmed these were documented and integrated into the care plans, including likes and dislikes, and attention to personal preferences around activities of daily living. A satisfaction survey confirmed that residents and family felt that their needs were being met.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Residents and family members interviewed stated that residents were treated with respect and were free from any type of discrimination, harassment or exploitation. The residents expressed that Methven House was a safe place to live. The induction process for staff includes education related to professional boundaries and expected behaviours. Staff are provided with a Code of Conduct and 'House Rules' as part of their individual employment contract including such things as treating the resident with respect for their values and

		beliefs and maintaining dignity and privacy at all times. Ongoing education is also provided on an annual basis, which was confirmed in staff training records. Staff are guided by policies and procedures and, when interviewed, demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The service encourages and promotes good practice with input available from external specialist services and allied health professionals, for example, community dieticians and physiotherapists, and education of staff. The GP confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests and the staff always maintained a high standard of professionalism. A referral was sighted for a wound care specialist. The RN interviewed reported that courses offered by CDHB are advertised on the staff notice board and that several staff have completed level three of Careerforce training.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Residents and family members stated they were kept well informed about any changes to their own or their relative's status, were advised promptly about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported by documentation in residents' records reviewed. There was also evidence of resident/family input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. Interpreter services can be accessed via CDHB when required. Staff knew how to do so. Interpreter services have not been required due to all present residents being able to speak English. All staff were observed to be wearing name badges.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	PA Low	Methven House is owned by the people of Methven and administered by a committee comprised of community members who operate as the Methven Aged Persons' Welfare Association Inc. The Methven Aged Persons Welfare Association Inc. oversees the management of Methven House via a management committee, a strategic planning committee, a human resources sub-committee and a nurse manager support group. There is a separate Methven Care Trust, which is a registered charity that has been established to fundraise for, and oversee, the development of the new aged care facility for Methven which will replace Methven House. A Methven Aged Persons Welfare Association Inc. strategy 2019 to 2021 includes a mission statement of 'Caring with Compassion and Dignity' and outlines a comprehensive philosophy. Three strategic

		goals refer to concepts such as providing quality care and to recruit, retain and train quality caring staff. It also notes the intention to ensure that the organisation maintains financial stability and engages with the community. A business plan is in the process of its annual review for 2020-2021 and already describes longer term objectives and associated operational plans. The nurse manager provides a monthly report to the board of trustees and a sample of these showed adequate information to monitor performance is being reported. The service is managed by a nurse manager who has a current practising certificate and has been in the role for approximately four months. Responsibilities and accountabilities are defined in a position description and an individual employment agreement. The nurse manager confirmed knowledge of the sector, regulatory and reporting requirements; however, a corrective action has been raised as this person has no previous management experience and has yet to undertake management training, especially in relation to rest home management. The service holds contracts with Canterbury District Health Board to provide rest home and respite care. Residents were receiving services under the Aged Related Residential Care Agreement.
Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.	FA	In the absence of the nurse manager, the registered nurse/assistant nurse manager carries out the required management duties under delegated authority. Both of the clinical staff, who are also the manager and the assistant manager, relieve for each other and may obtain additional support from the local medical centre if required. The employment of an enrolled nurse is currently underway. Staff are satisfied with the current levels of support available to them.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	PA Low	The organisation has a planned quality and risk system that sits within a business, quality, risk and management plan. This reflects the principles of continuous quality improvement, includes related goals and objectives and links with health and safety. Adverse event management, complaint management, internal audit outcomes, an annual resident satisfaction survey and hazard and risk reviews are integrated into the quality and risk system. The information is reported and discussed at monthly staff meetings and then the monthly management meeting, which occurs before the committee meeting. Staff confirmed their involvement in quality and risk management activities through assisting with audit activities and contributing to quality improvement initiatives. An opportunity for improvement (OFI) form has been developed and staff are encouraged to make suggestions. According to a purpose developed

		register of OFIs, this is working well as a number of positive changes have resulted from this system. Within the quality and risk system, corrective actions are developed, and action plans documented when necessary to address any shortfalls, especially following internal audits. However, there is minimal documentation confirming the outcome, nor evaluation of the effectiveness of the outcome(s). This has been raised for corrective action. The latest resident and family satisfaction survey was completed March 2019 with three key suggestions around odour within the facility, gardening services and residents' outings made. All three have since been addressed. Policies and procedures reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. The nurse manager and the assistant nurse manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies, as documented in the risk register. This organisational risk register is currently under review. A hazard register that is being maintained was sighted. Health and safety activities are ongoing, and the nurse manager informed that the three to four monthly health and safety meetings are moving to monthly to speed up the processes for review of the risk register. There is a high level of awareness of the requirements of the Health and Safety at Work Act (2015), which was evident in meeting minutes.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	Staff document adverse and near miss events on an accident/incident form. A sample of incident forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to staff meetings, where quality and risk issues are discussed and via the manager's monthly reports to the committee. An example of a change made as a result of medicine errors is the introduction of an electronic medicine management system. The nurse manager described essential notification reporting requirements. This person advised there have been no notifications of significant events made to the Ministry of Health, or other significant authority, since the previous audit.
Standard 1.2.7: Human Resource Management Human resource management	FA	Human resources management policies and processes are based on good employment practices and relevant legislation. The recruitment process includes interviews, referee checks, police vetting and validation of qualifications. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained. Records of annual practising

processes are conducted in accordance with good employment practice and meet the requirements of legislation.		certificates/registrations for all health professionals linked to Methven House are on file. Staff orientation/induction processes include all necessary components relevant to their role. Staff reported that the orientation process prepared them well for their role and that a new person may be offered additional days of buddying when requested, or if indicated. Staff records reviewed show documentation of completed orientation and a performance review after a three-month period and annually thereafter. All appraisal records sighted were current. Continuing education for staff, including for the mandatory training requirements, are planned on an annual basis. An applicable training schedule for most of 2020 was sighted. There are records of staff attendance at a wide range of education sessions both facility-based and for external opportunities. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. Both the nurse manager and the nurse manager assistant have completed their interRAI competencies.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	A good employer policy states it is the manager's responsibility to ensure staff work within their scope of practice and that staffing levels are safe for residents. The staffing levels and skill mix policy document notes the appropriate skill mix is reflected on the roster. The nurse manager or delegated person is responsible for ensuring that each shift is filled by a staff member with the appropriate experience and skills and staffing reflects residents' assessed needs. These features were evident in the six weeks of rosters that were reviewed. Rosters cover 24 hours a day, seven days a week (24/7). The nurse manager provided examples of how staffing levels had been adjusted to meet the changing needs of residents. An afterhours on call roster between the nurse manager and the assistant nurse manager is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Staff are replaced in any unplanned absence with a casual staff person, or a carer wanting additional hours. All carers who regularly work eight-hour shifts do a full first aid competency, therefore at least one staff member on duty always has a current first aid certificate. A diversional therapist works six hours a week on group activities and three hours for one on one activities over four days a week. Carers assist residents with activities when the diversional therapist is not on duty and when requested to support the diversional therapist.
Standard 1.2.9: Consumer Information Management Systems	FA	The resident's name, date of birth and National Health Index (NHI) number are used on labels as the unique identifier on all residents' information sighted, provided by the Methven Medical Centre. All necessary demographic, personal, clinical and health information was fully completed in the residents'

Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.		files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. Records were legible with the name and designation of the person making the entry identifiable. Residents' files are stored in an enclosed trolley in the manager's office. Archived notes are kept securely onsite and were readily available. No personal or private resident was on public display during the audit.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Transfer of residents is managed using the envelope system. The RN was able to explain the process and what copies of appropriate documentation were forwarded with the resident to inform of the ongoing management of the resident. The GP and family were involved in the decision to transfer and were kept informed at each stage. This was documented in the progress notes.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. A safe system for medicine management using a manual system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage. The competency register was sighted and is updated annually. Medications are picked up by the RN or CNM weekly in a pre-packaged format from a contracted pharmacy. These medications are checked by an RN against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request. On interview with

		the pharmacist, it was confirmed that he had been involved in giving a training session as confirmed by education record. There were no controlled drugs stored at Methven House but the RN confirmed that when required weekly and six-monthly checks are carried out. Medications that required refrigeration were stored in a container in the fridge with daily temperatures within recommended ranges sighted. Good prescribing practices noted included 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 reviews were consistently recorded on the three-monthly medicine review chart. There were no residents self-administering medications on the day of audit. Medication errors are reported to the CNM and recorded on an accident/incident form. The residents designated representative is advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	Meals are catered for by two cooks who each work four days on four days off. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years (February 2019). Recommendations made at that time have been implemented. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by Ministry of Primary Industries current until June 2020. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. Both cooks have undertaken a safe food handling qualification. A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, was available such as adapted cutlery. Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion. Files reviewed showed stable weight records. The cook explained that they make cakes for birthdays and special occasions.
Standard 1.3.2: Declining Referral/Entry To Services	FA	There have been situations were a resident has been refused entry to Methven House when the room available is a shared room and the proposed resident did not meet the entry criteria for a shared room. These people have remained on a waiting list or chosen to look elsewhere depending on the urgency

Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.		of the need for care. The GP and local NASC are advised to ensure the prospective resident and family are supported in finding an appropriate care alternative. If the needs of a resident change a referral for reassessment is made and a new placement sought in conjunction with the resident and their family. The RN interviewed shared how this had occurred once since the last audit.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Information is documented on admission using validated nursing assessment tools, such as, a pain scale, falls risk, skin integrity, pressure risk and nutritional screening, as a means to identify any needs and to inform care planning. The five care plans reviewed had an integrated range of resident-related information. All residents had current interRAI assessments completed by one of two trained interRAI assessors on site. Residents and families confirmed their involvement in the assessment process.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Plans reviewed reflected the support needs of residents and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed. Care plans evidenced service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required was documented and verbally passed on to relevant staff at handovers. Residents and families reported participation in the development of care plans.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Documentation, observations and interviews verified the care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input was sought in a timely manner, that medical orders were followed, and care was of a high standard. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available suited to the level of care provided and in accordance with the residents' needs
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements	FA	The activities programme is provided by a trained diversional therapist who works eleven and a half hours over the weekdays. During the weekend, suggestions are left for care staff to implement. The DT is supported by a group of women who come weekly and play 'housie'. The programme includes exercises, quizzes, crosswords, housie, music groups and visits from school children. When required a van is hired for outings. With an increase in hours since the last audit there is time to spend with

are appropriate to their needs, age, culture, and the setting of the service.		residents on an individual basis. A social assessment and history are undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated six-monthly. Any requests by residents are included, as confirmed by a resident who when interviewed said she had asked for more exercises and this had been added to the programme. Resident/family meetings are held six-monthly and minutes indicated satisfaction with the programme.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	PA Low	Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN. Examples of short-term care plans being consistently reviewed, and progress evaluated as clinically indicated were observed for wounds and urinary tract infections. Evaluations of DT care plans were detailed and used to formulate changes to the programme every six-months. Four of the five files reviewed had no evidence of evaluations or changes to interventions being made for service delivery. When the sample group was extended further service delivery plans reviewed also had no evaluations. A former staff member had been responsible for creating care plans the using interRAI system, the current RN did not have experience to use the system to populate care plans or make evaluations. The one evaluation sighted was on a paper-based system and a plan was put in place to use these until further training could be accessed.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	Residents are supported to access medical services from any of the GPs at the local medical centre. If the need for non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Referrals were sighted for specialist wound care assessment and physiotherapy that occurred after consultation with the GP. The RN stated that they made contact with district nurse services and dietitian as required. The resident and family interviewed confirmed that they were kept informed during the referral process. Any urgent/acute referrals were attended to immediately, such as sending the resident to hospital in an ambulance if circumstances indicated.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service	FA	Infection control policies and procedures include documented processes for the management of waste and infectious and hazardous substances. Staff were aware of the content of these documents. An external company is contracted to supply and manage all chemicals and cleaning products and provides relevant training for staff. Material safety data sheets were available where the cleaners are

providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.		stored, and staff knew about safe chemical handling. There is provision and availability of protective clothing and equipment and staff were observed using this when applicable.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	A current building warrant of fitness with an expiry date of 1 July 2020 is publicly displayed. Equipment such as handrails and shower chairs are available to assist with residents' safety. Appropriate systems were in place to ensure the residents' physical environment and facilities are fit for their purpose and suitably maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment, including weighing scales, was current as confirmed in documentation reviewed and observation of the environment. The environment was hazard free, residents were safe, and independence was promoted. A maintenance request system is in place and a maintenance register confirmed requests are appropriately actioned. Residents and family members interviewed informed that they were happy with the environment, which they described as 'homelike'. External areas are safely maintained and are appropriate to the resident group and setting. The nurse manager explained they were in the process of employing a gardener as the gardens are currently being maintained by a volunteer who no longer has the same time to do it as previously.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	FA	There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes a combined toilet and shower, a single shower room and two separate residents' toilets. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote resident independence. Privacy locks are in situ. Residents were satisfied with the shower and toilet facilities.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed	FA	Bedrooms are of varying sizes. Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. One double bedroom has a husband and wife couple sharing it, although one of them is currently absent from the facility. Two other rooms are usually shared with two residents; however, one of these

areas appropriate to the consumer group and setting.		has only got one person in it. Where rooms are shared, approval has been sought and this is included in the residents' agreement. All rooms are personalised with furnishings, photos and other personal items displayed. There was room to store mobility aids and wheelchairs. Staff and residents reported the adequacy of bedrooms. One person who uses a wheelchair chooses to stay independently in what is a small room until a larger one becomes available, rather than share a larger room. Staff are managing the situation well.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	Communal areas are available for residents to relax and engage in activities. The dining area is beside the kitchen and residents may access this at any time. A separate medium size lounge enables easy access for residents and staff. There is a communal television in this lounge and many group activities are undertaken in this area. Four residents' rooms have a small private sitting area beside them. Furniture is appropriate to the setting and residents' needs.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	Cleaning policy and procedures include a copy of the job description, duty schedule and cleaning methods. Laundry policies and procedures address laundry design, general infection control, chemicals used and general laundry processes including laundry equipment and usage. Personal laundry, hand towels and flannels are undertaken on site in a small dedicated laundry. One staff person on the day shift does most of the personal laundry; however, others on any shift may assist. Sheets and towels are taken to a local laundry for laundering. The staff person responsible for laundry on the day of audit demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner. All staff assist with cleaning duties with one person responsible for the main cleaning schedule each day. All staff have completed chemical handling training. Chemicals were stored in a lockable cupboard in the laundry and were in appropriately labelled containers. The laundry door has a high-level slide bolt, which is being changed to a digital lock for additional safety. Cleaning and laundry processes are monitored six-monthly through the internal audit programme. The nurse manager and assistant nurse manager will raise any issues of concern regarding laundry and cleaning duties when relevant. There were no corrective actions raised at the last cleaning and

		laundry audits.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	Policies and guidelines for emergency planning, preparation and response are available. These also include disaster and civil defence planning guides for the local Methven district and for the wider mid-Canterbury region. Procedures to be followed in the event of a fire or other emergency refer to the records of inspections and monitoring of fire safety systems. Staff training records informed that staff have undergone related training and staff confirmed their awareness of the emergency procedures. The current fire evacuation plan was approved by the New Zealand Fire Service on 20 December 1993. A trial evacuation takes place six-monthly with the most recent being on 17 September 2019. The orientation programme includes fire and security training. Adequate supplies for use in the event of a civil defence emergency, including food, blankets, radios and a gas BBQ were sighted and meet the requirements for full occupancy. Water storage tanks are located on site with additional water available in header tanks in the ceiling. Methven House has a Memorandum of Understanding with a local engineer for priority access to a generator in the event of a power failure. Call bells alert staff to residents requiring assistance and these were tested during the audit. Residents reported that staff responded promptly to call bells. A security policy states that at approximately 6-8pm, dependent on nightfall/weather, a client and building security check will take place. Regular security checks are completed by evening and night shift staff ensuring doors and windows are secured. The nurse manager confirmed these checks are occurring. A security company has recently reviewed the service provider's security requirements and has made some further recommendations that are currently being considered by the Trust.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows and five have doors that open onto outside garden or small patio areas. Heating is provided by electrically powered panel heaters in residents' rooms, the communal areas and the hallways. Areas were well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.
Standard 3.1: Infection control	FA	The service implements an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current

management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.		infection control manual. The infection control programme and manual are reviewed annually. The registered nurse is the designated IPC coordinator, whose role and responsibilities were defined in a job description (sighted). Infection control matters, including surveillance results, are reported monthly to the manager and discussed at the quality meeting. Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours, not to enter the facility. Signage also displayed asking about overseas travel in relation to Covid-19. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The IPC coordinator has appropriate skills, knowledge and qualifications for the role, and has been in this role for fourteen months. Training has consisted of articles online and in the Kaitiaki magazine, updates from New Zealand Aged Care Association and she is booked in for more formal training in the upcoming months. Support is available from CDHB, the GP and local medical centre. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections. The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	The infection prevention and control policies reflected the requirements of the infection prevention and control standard and current accepted good practice. Some policies were last reviewed in January 2020, others are due in March 2020 and were under review. Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.
Standard 3.4: Education	FA	Interviews, observation and documentation verified staff have received education on infection prevention and control at orientation and ongoing education sessions. Education is provided by the IPC

The organisation provides relevant education on infection control to all service providers, support staff, and consumers.		coordinator. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. Topics have included hand hygiene, outbreak management and food handling safety. There have been no outbreaks since the last audit. Education with residents is generally on a one-to-one basis and has included such things as reminders about handwashing, advice about remaining in their room if they are unwell and increasing fluids during hot weather.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. The IPC coordinator reviews all reported infections and these were documented. New infections and any required management plan were discussed at handover, to ensure early intervention occurs. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme were shared with staff via regular staff meetings and at staff handovers. Graphs were produced that identified trends for the current year, and comparisons against previous years and this was reported to the nurse manager.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Restraint minimisation and safe practice policies and procedures state the service provider is committed to promoting a restraint free environment and to providing the staff with good guidelines to prevent the need for restraint. A section on enablers emphasises the need for enablers to be voluntary. Staff training requirements and processes to be followed should restraint be considered are described. During interviews, staff sated they have completed restraint training, and this was confirmed in staff training records. Policy and procedures on managing challenging behaviours are also available. There were no enablers in use at the time of audit and the service provider has maintained its restraint free environment philosophy. A recent challenging situation was described and viewed in incident reporting records. Staff responded in a manner that precluded personal restraint from being required and this was attributed to the quality of staff training and reiteration of the organisation's philosophy. The restraint coordinator, who is currently the registered nurse/assistant nurse manager, is responsible for managing restraint minimisation and safe practice and their role and responsibilities are described in policy documentation. There is opportunity on the agendas of staff and quality management meetings to report on restraint and enabler training and on any use of these.

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)
Criterion 1.1.13.3 An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.	PA Low	A folder that included a copy of each complaint, all related correspondence and the final outcome was provided for review. The documents confirmed the service provider’s complaint policy and procedure had been fully implemented and the timeframes honoured. However, an up-to-date complaint register that includes all complaints, dates, and actions taken was not available as required by the standard.	There is not currently an up-to-date complaint register that includes all complaints, dates and actions taken.	A complaints register that includes all complaints, dates, and actions taken is instituted and maintained. 180 days
Criterion 1.2.1.3 The organisation is managed by a suitably qualified and/or experienced person with authority, accountability, and responsibility for the	PA Low	The previous manager of Methven House retired and according to the personnel file, a person with integrity and appropriate credentials has now been appointed for the position of nurse manager of this service. This was confirmed during interview with two committee members who described the appointment process. Despite extensive experience in a range of nursing fields, including 12 years as a local practice nurse, six years as a	There was a lack of evidence that the manager has suitable management qualifications, has experience managing a rest home, and nor have they attended professional	Ensure the rest home manager has attended suitable training and is undertaking the relevant ongoing professional development as required in clause (D17.3d.i.) of the ARC Agreement.

provision of services.		Methven House Trust committee member and occasional relief to support staff in the rest home, this person does not have previous management experience and has yet to complete formal management training. Although plans are reportedly in place for this to occur, contractual requirements of the ARC Agreement (D17.3d.i.) were not being met at the time of audit.	development related to managing a rest home.	180 days
Criterion 1.2.3.8 A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.	PA Low	Recommendations and corrective action plans are being identified as part of the internal audit process and other aspects of the quality and risk management system. Examples of actions having occurred were reported and confirmed either a positive result or helped identify a new approach was needed. Most records sighted stopped at the action plans and interventions and their outcomes were not evident. There was a lack of evidence of evaluation of the effectiveness of the corrective action plans.	Outcomes of interventions for corrective actions are not always being documented and there is a lack of evaluation of the effectiveness of the interventions.	The outcomes of interventions related to corrective actions are documented and the effectiveness of these are evaluated. 180 days
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.	PA Low	Care plans in the interRAI system showed no evidence of evaluations, either as needs change or in regular six monthly intervals. All existing care plans had been created by a former staff member. The current RN was unclear on how to use the interRAI system to complete evaluations which has resulted in no formal evaluation taking place in the last year.	Formal evaluations of care plans were not evident in the files reviewed. The interventions are not always being updated to reflect the current needs of the resident.	Assessments and service delivery plans are reviewed and evaluated six monthly in line with interRAI reassessments, or sooner if the condition of a resident changes, and this is documented in the residents' care plans. 180 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.