

Pohlen Hospital Trust Board - Pohlen Hospital Trust Board

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:	Pohlen Hospital Trust Board	
Premises audited:	Pohlen Hospital Trust Board	
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Hospital services - Surgical services; Hospital services - Maternity services	
Dates of audit:	Start date: 3 February 2016	End date: 4 February 2016
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:	22	



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

Pohlen Hospital Trust Board provides care for up to 27 clients including maternity, surgical, medical, rest home and hospital level of care. The facility is operated by a charitable trust. There are 22 clients receiving care on the first day of this audit. There were no patients receiving surgical services during audit.

There has been an extensive renovation and refurbishment programme undertaken since the last audit. A new six bed wing is in the process of being built but is not complete and was not included in this audit.

This certification audit was conducted against the Health and Disability Services Standards. The audit process included the review of policies and procedures, review of clients' files and staff files, observations, and interviews with clients, family members, staff (including the general practitioner and the nurse practitioner) and management.

There is a coordinated quality and risk programme that is implemented. Feedback from clients and family members was very positive about all aspects of the care and services provided.

The audit identified two areas for improvement required to meet these standards. These relate to food safety/hygiene training and maintaining the environment. Initiatives to reduce client falls and the use of volunteers ('Pohlen Pals') within the activity programme are particular strengths of the service and are rated as 'continuous improvement'.

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.

Staff interviewed demonstrated good knowledge and practice of respecting clients' rights in their day to day interactions. Management and staff are fully informed of the obligations of the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Education is provided to all staff at orientation and is ongoing. Advocacy and interpreter services are available if and when required.

There were no clients who identified as Maori using the services at the time of the audit. There are no known barriers to Maori clients accessing the hospital services, inclusive of the primary maternity service offered at the facility. Services are planned to respect the culture, values and beliefs of the clients.

Informed consent is obtained appropriately for each of the services provided as required. Signed consent forms were sighted in clients' files sampled from each service stream.

Linkages with family/whanau and the community are promoted and encouraged. Clients in the primary maternity service are able to have a nominated support person of their choice throughout all stages of service delivery.

Staff, clients and family members are aware of the complaints process. There is a high level of satisfaction expressed in relation to services provided. There are very few complaints received. The majority of client and family feedback is in the form of written compliments.

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.
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Pohlen Hospital Trust Board has a documented business and strategic plan which has been developed by the Board of Trustees. The mission, philosophy, scope and goals/objectives of the hospital are documented and monitored. The general manager and the clinical quality manager are both experienced registered nurses. They maintain current annual practising certificates and participate in relevant ongoing education.

The quality and risk programme includes complaints and compliments, incident and accident reporting, the undertaking of quality improvement projects, surveillance for clients with infections, audits, satisfaction surveys, policy/procedure review and risk and hazard identification and management. The results of quality and risk activities are discussed with staff regularly at monthly staff meetings, or sooner during shift handover where applicable. Corrective action plans are developed where required, implemented and monitored for effectiveness.

Human resources activities are managed. Staff files reviewed contained the results of police checks, employment contracts, confidentiality agreements and job descriptions. Staff performance appraisals are undertaken annually. Staff and contractors providing services have annual practising certificates where this is required.

An orientation programme is provided for new staff and records are retained. Staff have participated in regular relevant on-going education. This includes the opportunity to complete an industry approved qualification. Policy details staffing numbers and skill mix requirements. At least one registered nurse is on duty at all times. Improvement is required to ensure the cook has evidence of completing a food safety programme.

Client information is uniquely identifiable, accurate, up to date and accessible to staff when required. Client information was securely stored and not accessible or observable to the public.

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.	All standards applicable to this service fully attained with some standards exceeded.
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Pre-admission and admission information clearly and accurately identifies the services offered. The service agreements are signed appropriately for the long term clients.

Services are provided by suitably qualified and skilled staff to meet the needs of clients. InterRAI assessments are being implemented for clients assessed for rest home and hospital level care. When changes in the client's needs, short term care plan is developed and implemented to reflect this. Clients admitted to other services provided also have a full assessment completed by a registered nurse and appropriate care plans are documented to reflect and meet the needs of the individual client. Evaluations occur for all clients irrespective of service provided, in appropriate time frames. There is a team approach and continuity of service delivery is promoted.

The general practitioner and/or the nurse practitioner and lead maternity carers review their respective clients and referrals are planned and co-ordinated, based on the individual needs of the client.

The services provide planned activities and clients are encouraged to maintain links with family/whanau and the community.

A safe medication system was observed at the time of the audit. The staff responsible for medication management have completed annual competencies. In the primary maternity service the lead maternity carers are responsible for prescribing medication for their client.

The clients` nutritional requirements are effectively met by the service with preferences and special diets being catered for appropriately. The service employs experienced staff who prepare the meals. The menu plans had been approved by a registered dietitian. Click here to enter text

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.		Some standards applicable to this service partially attained and of low risk.
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Policies and procedures are available to guide staff in the safe disposal of waste and hazardous substances. Appropriate supplies of personal protective equipment are readily available for staff use.

The building has a current building warrant of fitness. Clinical equipment has a current calibration. Electrical safety checks of electrical appliances have been undertaken in 2015. The temperature of hot water in patient care areas is monitored and is above the required temperature on some occasions. The medical gas manifold is overdue performance monitoring checks. These areas need to be addressed.

The two facility vehicles have a current registration and warrant of fitness. Security cameras are present in the observation area. Security processes are in place and includes monitoring by a contractor.

There are eleven single occupancy bedrooms, six share twin bedrooms, and one room (the observation area) contains four beds. Each bedroom has access to an ensuite, with some shared between two rooms. Call bells are present in the bedrooms and bathrooms. Personal space is sufficient, including for those who require staff assistance or the use of mobility devices. There is a large lounge and dining area. A quiet room is also available to clients and family members. There is good indoor/outdoor flow with

each room having an external door to the grounds. The facility has adequate heating and ventilation. Smoking is allowed only in a designated outside area.

Cleaning is provided by a contractor. Laundry services are provided by employed staff. These services are monitored through the quality programme and residents' meetings.

Emergency policies and procedures provided guidance for staff in the management of emergencies. There is an approved fire evacuation plan and fire evacuations drills have been conducted at least six monthly. The fire sprinklers have been upgraded since the last audit. There is sufficient supplies available on site for use in the event of emergency or an infection outbreak. Emergency utilities includes an on-site water tank, solar power and a generator.

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 service has documented policies and procedures for restraint minimisation and safe practice which are reviewed annually. A flow chart is also available to guide staff. Staff confirmed that enabler use would be voluntary and the least restrictive option. One client is using an enabler and one client a restraint, at the time of the audit. There are clear definitions of an enabler and restraint. There are good processes in place to manage both enablers and restraints, including consent, approval, monitoring, evaluation and monthly reviews. The care plans are up dated if any changes occur.

Staff receive education on restraint management at the time of orientation and on an ongoing basis. Staff demonstrated a sound knowledge and understanding of restraint and the use of enablers.

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 service has an appropriate infection prevention and control management system. The clinical quality manager is responsible for facilitating the infection prevention and control programme. The infection control programme is understood by staff. Current policies and procedures are available to guide staff practice. Relevant education is provided for staff and when appropriate the residents.

There is an ongoing surveillance programme, where infections information is collated, analysed and trended with previous data. Where trends are identified actions are implemented to reduce infections. There have been no outbreaks of infection since the last audit. The infection surveillance results are reported and discussed with the infection control committee, the quality committee and at staff meetings. Monitoring of antimicrobial use is also occurring.

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	2	46	0	2	0	0	0
Criteria	2	97	0	2	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	<p>The Code of Health and Disability Services Consumers' Rights (the Code) is displayed in the reception area of the hospital, in the ward and in the maternity unit. The staff interviewed stated the rights of residents are respected.</p> <p>Staff receive training on the Code at commencement of employment as part of the orientation/induction process. The clinical staff interviewed demonstrated knowledge on the Code and its implementation in their day to day practice.</p> <p>The Code is available in English and Maori and other languages for residents with English as a second language.</p>
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	FA	<p>Systems are in place to ensure residents, and where appropriate their family/whānau are provided with appropriate information to make informed choices and informed decisions. The nurse practitioner and registered nurses interviewed demonstrated a good understanding in relation to informed consent and informed consent processes. Family and clients interviewed confirmed they have been made aware of and understand informed consent processes and that appropriate information had been provided.</p> <p>Informed consent is required prior to surgery or procedures requiring sedation and this is now clearly documented in the informed consent policy. This was identified in the file reviewed for the primary care</p>

		<p>informed consent.</p> <p>tracer methodology.</p> <p>Policies and procedures implemented are available to guide staff.</p> <p>A multipurpose informed consent form is utilised by the service provider including consent for outings or activities. This is contained in the service agreements reviewed. A copy of the consent form is in each client's individual records sighted. Additional consents for the annual influenza vaccination are also in the records sighted. Forms are dated and signed appropriately. Full explanations were provided by the registered nurses, nurse practitioner or the general practitioner.</p> <p>The admission agreements were signed and dated by the provider and the client and/or representative. The general manager ensured these were all signed, filed and stored appropriately.</p> <p>The GP interviewed understands the obligations and legislative requirements to ensure competency of residents as required for advance directives and reviews are undertaken six monthly. All clients are for resuscitation unless an explicit decision has been made and documented.</p> <p>The registered nurses interviewed reported that education was provided on the principles and practice of informed consent as part of the Code of Rights.</p> <p>Maternity: The LMCs and the maternity aide interviewed demonstrated their ability to provide information that clients required in order to make informed decisions and informed choices and to be actively involved with their care based on information provided to them. Staff and LMCs also acknowledge the client's right to withdraw consent. All patients and their babies are for resuscitation due to the nature of this service. Informed consent is obtained for a number of procedures, such as the Guthrie test for the baby, administration of Vitamin K for the baby after birth, the requirements of Baby Friendly Hospital Initiatives (BFHI), and administration of 'anti D' by the midwife for a client if needed.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>The advocacy policy is available to guide staff. All clients receiving care at the facility under all service streams have appropriate access to independent advice and support, including access to cultural and/or spiritual advocates as required.</p> <p>Family and clients interviewed reported they were provided with all relevant information regarding access to advocacy services. The contact details of the Nationwide Health and Disability Advocacy Service is in the resident information pack provided on entry to all services. The contact numbers are also documented on the reverse of the Consumers' Rights brochure.</p> <p>Staff education is provided as part of the orientation programme for all new employees and is ongoing as evidenced in the education plan and confirmed by staff interviewed.</p>

<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Family/whanau friends and volunteers (Pohlen Hospital Pals) are encouraged to visit at any time and family are able to and encouraged to participate in the activities programme if they wish to do so. Outings with family members are encouraged and clients are able to go out once a fortnight in the community as arranged. Family are invited to join the residents on special event days. Photographs on the wall in the activities lounge evidence this does occur.</p> <p>Families interviewed reported that they are kept well informed. Records reviewed provided evidence that families are contacted by staff if any significant event or changes occur.</p> <p>Maternity: Information is provided to all clients on activities and support groups in the community as part of the discharge process. Family and friends can visit anytime with the client's consent.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy details the client's or family member's right to make a complaint. The process for reporting, investigating, documenting and following up the complaint was documented and the timeframes aligned with the requirements of the Code.</p> <p>All clients and family members interviewed confirmed being aware of the complaints process and have no complaints. The staff and managers interviewed were able to detail their responsibilities in the event a client made a complaint.</p> <p>A complaints, compliments and feedback register was sighted. Very few complaints are received and these have been acknowledged, investigated and responded to in a timely manner. The majority of client feedback sighted is in the form of written compliments about the staff and services received.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>A copy of the Code and information about the Nationwide Health and Disability Advocacy Service is provided to the client and family on admission and the registered nurses go through the Code with the client/family/whanau during the admission process. Contact details for an advocate in this region are readily available.</p> <p>The family members that were interviewed reported that the Code was explained to them on admission. Interviews with clients who were able to provide insight into their care, expressed that they were treated with the respect and were pleased with the care provided at this hospital.</p> <p>An interpreter service is available through the Waikato District Health Board (WDHB) and local services can be utilised if required. Contact details are readily accessible to staff if and when required. The registered nurses and hospital aides interviewed displayed knowledge of the Code and demonstrated respect to all residents.</p>

		<p>Maternity: The Code and advocacy services information was discussed with the Lead Maternity Carer Midwife (LMC) at the initial point of contact with the client and discussed with the maternity aide during the booking process. Additional information available included family violence screening, counselling and smoke free information. The Code was also documented in the client record book given to each client by the LMC at the first visit. Client rights are documented specifically for women using a maternity service and were developed and implemented by the New Zealand College of Midwives (NZCOM). Appropriate and accessible information is also provided in the information pack on the locker in each maternity client's room on admission.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>The privacy policy requires that the visual privacy and personal space of clients is to be respected and observed at all times. The wishes of clients are acknowledged, sexuality and personal rights are upheld and independence maintained, maximised and encouraged for all services provided. The general practitioner and LMCs interviewed reported that visits are conducted for each client in their own individual rooms and privacy is respected.</p> <p>The clients' records reviewed indicated that clients received appropriate services that were responsive to their needs, values and beliefs of culture, religion and ethnicity.</p> <p>The families interviewed reported satisfaction with the way the services meet the needs of their relatives. Church services are provided weekly at the facility and church visitors and volunteers are welcome to visit and do so on a regular basis.</p> <p>No concerns were raised in relation to abuse and neglect from clients, the clinical quality manager, the general practitioner, family and/or staff interviewed. Staff have received education and understand their responsibilities along with who to report to if abuse and neglect was suspected with a client or a staff member. Comments received reflected a positive atmosphere from staff and family.</p> <p>Maternity: Maternity aides employed specifically for the maternity service are trained in family violence screening. Screening is also foremost a responsibility of the LMC during all stages of service delivery. If any women are at risk the staff are alerted to this through the booking and handover processes in place.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their</p>	FA	<p>The service has cultural policies which provide a framework for clients receiving culturally appropriate care. The policy details commitment to the Treaty of Waitangi and four cornerstones of health. Cultural supports are detailed for Maori clients. There are currently no clients that identify as Maori. Two Maori staff are employed.</p> <p>The registered nurse interviewed stated that staff are trained and capable of working with all clients in their care. The provision of culturally appropriate services and the identification and reduction of any</p>

individual and cultural, values and beliefs.		<p>barriers are part of the Maori Health Plan and policy objectives.</p> <p>A kuia is available for blessing rooms and a kaumatau of the Pohlen Trust Board are available. Maori health advisors can be sought from Raukawa and Ngati Hauora services as required.</p> <p>The registered nurses, hospital aides and maternity aides interviewed demonstrated good understanding of services that would need to be provided for Maori clients to meet their identified needs, and the significance of whanau and whanau involvement in all stages of service delivery.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The spiritual, religious and cultural policies and procedures provide information to guide staff on the correct protocol. A cultural needs assessment tool is available to ensure the identified needs can be effectively met. The registered nurses and hospital aides interviewed have an understanding for promoting health and wellness for all clients.</p> <p>Staff interviewed reported they received training in cultural awareness and respected all cultural needs in their everyday practices.</p> <p>Family are able to provide assistance and advice if requested by the client in regards to assisting and identifying the individual values and beliefs during the assessment process.</p> <p>Maternity: Women are able to choose who they would like to have as their support person during all stages of service delivery. This is discussed in partnership with their LMC and details are recorded on the birth plan. When the client has delivered their baby and stay for the postnatal care and management a support person is nominated with consent of the client and can stay overnight. A consent form is signed and dated by the client and the maternity aide.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Policy details the organisation's commitment to providing a safe environment that is free of harassment, bullying and discrimination. Clear definitions of types of discrimination are documented to guide staff. Formal and informal processes to report these behaviours are detailed.</p> <p>The human resources policies detail various levels of staff behaviour/misconduct and how these will be effectively managed. The registered nurses have attended compulsory training on professional boundaries; a requirement by the New Zealand Nursing Council. All staff are provided training on the staff code of ethics as a component of their orientation.</p>
Standard 1.1.8: Good Practice	FA	<p>The clinical quality manager and the registered nurses promote and encourage best practice with staff. Evidence of this was demonstrated during the audit with medication management safety, the latest</p>

Consumers receive services of an appropriate standard.		<p>wound care products being available, and the hospital services being overseen by an experienced nurse practitioner who was available for interview.</p> <p>The service has several quality improvement programmes in progress, one of which is the falls prevention programme, which is referred to within the continuum of service delivery section of this report (criterion 1.3.4.2). The policies and procedures are managed by the clinical quality manager and the general manager and signed off appropriately. Both are very experienced registered nurses who have worked in aged care residential services, acute care and other services. Feedback from clients and family/whanau is very positive.</p> <p>Maternity: The maternity aide responsible for the maternity service is very experienced in the day to day management of this service, clearly understands the responsibilities for this role and is well respected by the LMC access agreement holders interviewed. Feedback from clients is exceptional about their birthing or postnatal stay experiences at the facility and the staff involved.</p>
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	<p>The open disclosure policy is clearly documented to include communication principles. The policy was further enhanced after the documentation review. Clients and family have a right to know what has happened to them and to be fully informed. There is a family/whanau communication record in the front of all residents' files reviewed.</p> <p>The cultural appropriateness policy documents that clients and families who do not speak English shall be advised of the availability of an interpreter or an advocate at the first point of contact with the service.</p> <p>The service promotes an environment that optimises communication and staff education related to appropriate communication methods. The GP interviewed spoke highly of the staff and the excellent communication and relationship between them and the GP and also the effective communication with the contracted pharmacists.</p> <p>The staff interviewed meet for the '11am huddle' daily, which is a time for all staff to discuss any issues, progress of the day, or if additional assistance is required to meet the needs of the clients. Handover between shifts is well managed and staff interviewed reported they felt well informed before commencing their respective shift.</p> <p>Families interviewed confirmed they are kept well informed of the client's status, including any adverse events affecting the client. Evidence of open disclosure is documented in the residents' records reviewed and on the incident/accident forms sighted.</p>
Standard 1.2.1: Governance	FA	Pohlen Hospital Trust Board has a documented vision 'Pohlen: where community and health come

<p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>		<p>together'. The mission statement and values are reviewed regularly. The current objectives/goals are documented in the business and strategic plan (2014-2016). A strategic planning day is being planned for the development of the ongoing plan. The chair of the Board of Trustees during interview confirmed being kept informed of relevant business, financial and quality and risk activities. There are currently six trustees, and two additional representatives who are working with the trustees.</p> <p>The general manager and the Board of Trustees monitors the progress in achieving these objectives/goals via the quality and risk programme, review of client and family satisfaction and formal review of progress in meeting objectives which occurs during the monthly Board meetings.</p> <p>The day to day operations and ensuring the wellbeing of clients is the responsibility of the general manager who has been in the role for over two years. The GM is an experienced registered nurse with a current annual practising certificate (APC). The GM has relevant past experience in senior management roles in a variety of health services. He has a post graduate diploma in health management. The GM is assisted by the clinical quality manager (refer 1.2.2). The GM has participated in more than eight hours of education relevant to managing an aged care service as required to meet the provider's contract with Waikato District Health Board.</p>
<p>Standard 1.2.2: Service Management</p> <p>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.</p>	FA	<p>In the general manager's absence the clinical quality co-ordinator is responsible for service delivery (with the support of the Board of Trustees as required). The clinical quality manager is an experienced registered nurse who maintains a current annual practising certificate. The clinical quality manager has been working at Pohlen Hospital for seven years with the last two years as the clinical quality manager, and can detail the responsibilities in the general manager's absence.</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>	FA	<p>There is a documented quality and risk plan and this was sighted.</p> <p>Policies and procedures are available to guide staff practice. The policies are reviewed and updated by the general manager and clinical quality coordinator. Policies have been reformatted and the layout standardised. Changes in policy are discussed at staff meetings and during in-service education as verified by staff and managers interviewed and referenced in meeting minutes. Document control processes are implemented and out of date policies are archived by an administrator.</p> <p>A review of the quality and risk activities is undertaken at the quality forum, the health and safety committee, and the infection prevention and control committee. Results of quality and risk activities are</p>

		<p>also discussed at staff meetings. The minutes of at least the last three meetings for each committee were reviewed and included discussions on hazards, complaints and compliments, changes to policies/procedures/practices, the results of audits, security, education, the use of restraint, infection data and the number and type of reported incidents. The various committee meeting minutes and associated quality data is displayed on the staff noticeboard as observed during audit and verified by staff as being normal practice.</p> <p>Internal audits have been undertaken and are conducted using template forms. A schedule details what audits are to be undertaken and when. The eleven audits sampled during audit identified there is good understanding by staff in meeting the requirements of the organisation's policy and the audit criteria. Where improvements were required these improvements have been documented, implemented and monitored for effectiveness.</p> <p>A client satisfaction survey is conducted. This is continuous for all clients in the maternity service. Satisfaction surveys of other clients occurs on a scheduled basis. Clients can also complete feedback forms which are readily available throughout the facility. Feedback from clients is very positive. A staff satisfaction survey has also been conducted.</p> <p>Quality projects are planned and undertaken. Examples of projects completed since the last audit include recruiting volunteers (Pohlen Pals), the design of a new inpatient wing, reviewing food services and dining room experience for clients, and reformatting policies and procedures.</p> <p>Resident meetings are held. Minutes of the last three meetings (June 2015 to January 2016) sighted reflected discussion on food, the activities programme and care related topics. Client compliments were recorded and communicated to staff.</p> <p>Staff are required to report any hazards. Where hazards/maintenance concerns have been identified these have been eliminated or minimised. A hazard register was available that detailed a range of hazards related to the facility/environment as well as resident care. The mitigation strategies have been detailed. The hazard register is updated when new hazards are identified. Other hazards are regularly reviewed.</p> <p>A risk management plan is in place. Organisation risks are categorised and documented and mitigation strategies noted. The general manager and the chairman of the Board were able to discuss changes in organisation risk and demonstrated the process of reviewing risk. The risk register is discussed at the Board of Trustee meetings.</p>
Standard 1.2.4: Adverse Event Reporting	FA	<p>There is an incident reporting policy which is implemented by staff. Applicable events are being reported, investigated and responded to in a timely manner. Staff complete the incident form and then provide it to the RN on duty for initial management of the event. The clinical quality co-ordinator</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>		<p>monitors and analyses these events and ensures appropriate investigations and interventions have occurred in a timely manner.</p> <p>The clients' care plans are used to provide guidance for the caregivers following reported incidents. The sample of incident reports reviewed at random including medication errors, client falls, skin tear/wounds, episodes of challenging behaviour, and a maternity related event demonstrated prompt reporting, investigation and follow-up was occurring. Reported events are discussed at the quality forum, and monthly staff meetings as confirmed by staff and managers interviewed and verified in the meeting minutes sighted.</p> <p>A register is maintained each month of all reported events. The register details the date, resident and details of each event. The number and type of incidents is analysed for each month. A project has been implemented to reduce the incidents of falls. The falls rate has reduced by over 60% since the comprehensive falls prevention strategy was implemented. This is an area of continuous improvement. (Refer to 1.3.4.2.)</p> <p>The general manager is able to detail the events that require notification and this includes the Ministry of Health, the DHB, the coroner, the Ministry of Business and Innovation. The general manager advises there has been one event that has been notified to the Ministry of Health and two events notified to the DHB. The management team is aware of the recent communications from the MOH in relation to Section 31 reporting.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	PA Low	<p>Policies detail the process that is required related to human resources practices. The policy aligns with current accepted practice. Reference checks, interview records and the results of a police check are in the staff and managers' files reviewed.</p> <p>Annual practising certificates (APC) for all registered health professionals (both employed and contracted) are verified as being current. The drivers' licences for applicable staff and managers are also current. A register is maintained of this information and regular audits are conducted of these processes. An administrator maintains the register of the lead maternity carers (LMCs) who hold an access agreement to Pohlen House Trust Hospital. Copies of the APC and indemnity insurance is monitored.</p> <p>Staff confirmed they are provided with an orientation to the facility, individual clients and to their individual role and responsibilities. Records are available to evidence this. Staff are buddied with a senior staff members for a designated period which is individualised per employee. Staff report being well supported during the orientation process. Identified competencies are assessed. Self-learning packages are completed.</p> <p>Staff have undergone an annual performance appraisal. The format of the appraisal has changed in</p>

		<p>recent months and now more clearly aligns with the employee's job description.</p> <p>Staff ongoing education is well planned and provided. Records are not available to demonstrate the cook has a food safety certificate.</p> <p>Registered nurses are required to have a current first aid certificate. Certificates sighted are current and there is ongoing monitoring of when these are due for renewal. One RN is booked to attend the training the week following audit and evidence of this was sighted. The registered nurses are also provided with training on managing maternity related emergencies.</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>A policy details staffing requirements and this references the staffing skill mix, client care needs, and contract requirements. The general manager is responsible for developing the staff roster. There is at least one hospital aid and one registered nurse on duty at all times. During the day there are between three and four hospital aids working in the main ward. An additional hospital aid is on duty in the maternity service whenever a client is present. There are two additional registered nurses rostered on duty one day a fortnight when day surgical procedures are undertaken. Procedures are performed under local anaesthetic or with the use of intravenous sedation only. An additional RN is on duty when intravenous transfusions are scheduled. At least one member of the management team is on call when not on site. This is confirmed by staff and managers interviewed. Catering, laundry services and maintenance activities are covered by rostered staff. The cleaning services is contracted to an external provider although this will change at the end of February 2016.</p> <p>An activities coordinator is employed and works rostered hours. She is supported by volunteers (Pohlen Pals). Refer to 1.3.7 for details of this programme that has been awarded a continuous improvement rating.</p> <p>All clients and family members interviewed advised the clients received timely and appropriate care from all staff.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>Personal information is entered in all residents' records reviewed. The interRAI process is clearly followed by the registered nurse and the clinical quality manager when completing the interRAI assessments. Records reviewed evidenced entries being documented which are legible with signatures and staff designations included. All individual records reviewed are integrated with divisions labelled accordingly making records accessible. Clients' records in use are stored in the nurses' station in a filing cabinet. Client information is not displayed in public view without consent being obtained. Client names are displayed on the doors of clients' rooms.</p> <p>A hospital client register is maintained electronically by the administration staff. Information entered into</p>

		<p>the client information management system is recorded in an accurate and timely manner. All client information for the clients entering and discharging the service for all service streams, with the exception of maternity, are entered onto this register. Service agreement obligations for record management and legislative requirements are effectively met.</p> <p>Staff records are maintained by the general manager and stored confidentially in a locked filing cabinet. A system is in place for accessing archived records if and when required.</p> <p>Maternity: Individual client record books were reviewed and were accurate and up-to-date. All assessments of the mother and baby were documented.</p> <p>The maternity service register is maintained by the maternity aides. The information reviewed was documented for both the mother and the baby. National Health Index Number (NHIs) are obtained for any baby born in the facility. The LMCs obtain NHI numbers for the baby if they birth at the DHB and come to the maternity unit for the postnatal stay. All information obtained and recorded is appropriate for this service type and setting. Statistics are able to be obtained from the information recorded to meet the monitoring requirements of the WDHB agreement.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>The administrators system for recording all pre-admission enquiries. There is a client information pack available for clients entering the service. The service agreement is based on the Aged Care Association agreement which has been individualised for this service. The client agreements are signed and dated and stored confidentially in the general manager's office. The admission agreement identifies any additional charges that are not covered by the service agreement and the relevant costs of each charge required.</p> <p>The long term care clients have been pre-assessed prior to admission as requiring rest home or hospital level care. The DHB Needs Assessor Service Co-ordinators (NASC) Disability Support Link, ensure the interRAI pre-assessment documentation is made available to the registered nurses when a client is admitted. Some clients are admitted directly from the DHB but have been assessed and authorised for long term care by the geriatrician.</p> <p>Key entry criteria is documented for primary in-patient care clients/GP/NP clients who are admitted by a GP/NP booking system for acute and chronic care, rehabilitation or uncomplicated procedures, assessment or stabilisation to be undertaken. There is one palliative care client and one private client receiving care on the day of the audit. Clients are accepted also for transitional and respite care services. The service also provides surgical services following consultation with the visiting surgeon.</p> <p>Two registered nurse are fully trained to perform the interRAI assessments for each long term care client. The summary outcomes are printed out and placed in the front of each individual client's record.</p>

		<p>Maternity: Pohlen Hospital is a primary care maternity facility. Lead Maternity Carer Midwives (LMCs) have signed and dated access agreements to utilise this facility for their clients. Women if suitably assessed as low risk can labour and birth at this facility or deliver at WDHB and transfer for the postnatal stay. It is the responsibility of the LMC to ensure that the individual client meets the criteria for entry to this service. The criteria is clearly documented. Clients who have had a Caesarean Section are also able to be transferred when stable to the facility. The LMCs are responsible for their own clients and assessments are done at each point of contact with the client and documented in the individual client's file. The records are maintained by staff for both the mother and baby during their stay in the facility.</p>
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	<p>The NP and registered nurse interviewed stated that any risks identified prior to discharge or transfer are documented. A transfer form is utilised if a client is transferred. Staff and the GP concerned ensure open disclosure between services and family/whanau related to all aspects of service delivery occurs. This includes clients for either discharge and/or transfer to home, another facility or to the DHB.</p> <p>If there are any specific requests or concerns that the client or family want discussed, these are noted on the transfer form. The discharge summary and copy of the care plan summary is provided and covers all personal cares and needs of the client and any interventions required. Any identified risks, alerts, concerns are highlighted. A copy of the medication record with any known allergies or sensitivities, the client interRAI summary record and any advance directives, also accompany the client, if they are transferred to the DHB. If transferred to another facility a full interRAI is required for long term care (LTC) clients and this is completed by the registered nurse. Family are kept informed throughout the discharge and/or transfer process. Discharge summaries are completed for day stay clients and other users of the service for provision of continuing care.</p> <p>Maternity: Clients are discharge after forty eight hours of admission to the postnatal, stay rooms as per the requirement of the Waikato District Health Board Agreement. An additional length of stay can be arranged if necessary. The discharge summary is completed in the maternity notes. The discharge process commences on admission with a list of goals to achieve prior to discharge if possible within the required timeframe. The record book is photocopied for the service to retain and records are stored appropriately by the general manager.</p> <p>Staff and maternity aides are educated to manage any transfers from the service to the DHB. Transfers can be arranged by the LMC if the need arises. For example a client not progressing in labour, an undiagnosed unfavourable position of a baby, antepartum or postpartum bleed, obstetric emergencies or baby emergencies. The incidence is low due to the entry criteria being effectively managed. The client would be kept well informed and the partner/family/whanau. Documentation of incidents are accurately recorded by staff and LMC. The referral and transportation is arranged as soon as possible to</p>

		<p>Waikato Hospital. The client file is photocopied for the service records. The original notes go with the client. The LMC accompanies the client.</p>
<p>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.</p>	FA	<p>Medication policies are accessible to guide staff. The sighted policies meet legislative and best practice guidelines. The GPs/NP oversee the clients' medication management. The registered nurses, one enrolled nurse and maternity aides have completed annual medication competencies. The registered nurses also complete intravenous competencies two yearly. A list of registered nurses who are able to administer medication standing orders is documented. The GPs' standing orders are reviewed annually and signed off by the GPs individually.</p> <p>Medicines are received from the contracted pharmacy in a pre-packed delivery system. The medications are checked for accuracy by the registered nurses. The medications are stored in locked cupboards and a medication trolley sighted. The controlled drugs are checked by the pharmacist every Wednesday. A specimen signature is available to verify signatures if needed. There is a clear process for any medication incidents/events.</p> <p>Temperature monitoring occurs for the medication fridge. There are no LTC clients who are self-medication. A policy is in place if required. The registered nurses are responsible for the day stay and short term care clients and systems are in place for managing the clients' medication as required.</p> <p>A safe system for medication management was observed on the day of the audit. The GP interviewed stated there have been no significant medication errors in which the GP has been involved. The registered nurses can contact the GP/NP with any queries or points of clarification if needed due to the mixed caseload of clients.</p> <p>The medication records randomly selected and reviewed have all been reviewed in a timely manner. All medicines are prescribed individually on the records reviewed. Photographic identification is evident for the LTC clients on the medication records sighted. A system is in place for medication returns to the pharmacy. These are recorded and monitored. PRN (Pro-re-nata – as required) medication is monitored by the registered nurses and the NP. Education and training is provided for all staff on a regular basis and having a NP onsite is an advantage for this service.</p> <p>Maternity: The LMCs are responsible for medicine management of clients in labour and during the birth. Postnatally any prescribed medication by the LMC is administered by the maternity aides which is double checked with a hospital registered nurse. The LMCs can prescribe within their scope of practice. The mother and baby have their own separate medication records. The clinical quality manager oversees the maternity service.</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 team leader of kitchen was available for interview. The team leader has been at the facility for seven years and is employed Monday to Friday. The menu plans are three weekly and have been reviewed by a dietitian. Summer and winter menus apply. The team leader is assisted by two kitchen hands daily. The service caters for all clients and is able to meet their needs as defined in the nutritional assessment performed by the registered nurses for all clients on admission. A copy is provided to the team leader for planning purposes. Any special requirements are documented on the whiteboard in the kitchen to remind staff. An experienced second cook covers the weekends and relieves as required. Refer to criterion 1.2.7.5 with regard to evidencing food safety education and training.</p> <p>The kitchen has undergone extensive alterations and improvements have been made since the previous audit. The kitchen is very well designed with all new appliances being available.</p> <p>The team leader is responsible for ordering all food supplies. Some local providers are still utilised in the community. All deliveries are checked on arrival and temperatures of foodstuffs are maintained at point of delivery, storage and at time of serving. Policies and procedures are available. Separate cleaning schedules and temperature monitoring requirements are met. Kitchen waste management is managed effectively. All food in the pantry and fridges is labelled appropriately.</p> <p>Annual service satisfaction surveys are completed by clients/family included the food service. The clients, families interviewed reported satisfaction with the meal service inclusive of choices made available and presentation of meals.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>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.</p>	<p>FA</p>	<p>The policy sighted notes clients must be eligible for services at Pohlen Hospital. The registered nurse interviewed reported that the service does not refuse a client if they have been assessed appropriately for the level of care provided. The service has arrangements with the DHB to provide service streams as documented in policy and the service agreements. In the event a client is declined the client is to be informed and advised of alternatives. A record of refusals and the reason is to be maintained by the hospital administrator on the electronic bed state system in place. The administrator interviewed reported that this information applies for clients of all service streams.</p> <p>Maternity: Declining entry to this primary maternity service is only if the client is assessed as being at risk and/or not meeting the entry criteria. Past obstetric history is also taken into consideration when determining risks. This is the responsibility of the lead maternity carer. The booking process applies. Any declined entry would be documented in the maternity client register.</p> <p>Should a woman arrive in labour who is not booked into the facility for the labour and birth, arrangements would be made with the midwife on call. If possible a lead maternity carer would be arranged, if safe to do so due to the nature of this service, and/or alternatively the woman would be</p>

		referred directly to Waikato Women's Health, as soon as possible.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	CI	<p>An interRAI summary is evident in all long term care clients' records reviewed. Any additional assessments, as required, are completed by the registered nurses, such as risk assessments, falls assessment, pain assessments, cultural assessments and others depending on identified needs for the individual client. All other clients admitted for services at Pohlen Hospital are admitted on a referral basis and any appropriate assessments are completed in a timely manner. The referral information and the assessment is the basis of service delivery provided. Projects have been developed inclusive of the falls prevention project which has involved team work of all staff.</p> <p>Results of the assessments are discussed with the client, staff and family and included in the care plan as needs with appropriate interventions in place.</p> <p>Clients, staff and families interviewed reported appropriate care is provided that meets identified support needs and preferences are taken into account.</p> <p>Maternity: The service provider has an assessment room which can be utilised by the lead maternity carer for women at any stage of their pregnancy for an assessment if in early labour. The assessment room is well equipped and all resources are accessible. The LMC is responsible for assessing the client at each stage of service delivery and ensures choices of the client are safely met and recorded accurately and appropriately. The LMC ensures any identified needs are documented to serve as the basis of care delivery at whatever stage of service provision that the client is receiving. The maternity aides are experienced in maternity care and confirmed at interview that any changes and/or outcomes for the mother or baby are communicated to the LMC and the client.</p>
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	<p>The clients' records reviewed have care plans that address the client's abilities, level of independence, identified needs, deficits, and takes into account the client's habits and idiosyncrasies. The comprehensive interRAI assessment summary includes triggered outcome scores and the needs, identified by the registered nurse completing the individual assessment, and any other findings which are documented onto the existing care plan. The NP oversees the care planning for all hospital level clients and was interviewed on the day of the audit and was making changes as required to ensure all care plans were up-to-date.</p> <p>The individual care plans and individual activities plans identified client's activities, motivational and recreational requirements with documented evidence of how these are managed effectively for each individual client. Short term care plans are used as applicable and those sighted were documented with the problem, interventions and outcome.</p>

		<p>Other clients entering the service for other services provision all have a nursing assessment and relevant care plan which was reviewed during their stay in the hospital.</p> <p>The clients` records sighted demonstrated service integration and service delivery plans that were developed after appropriate assessments had occurred.</p> <p>Staff interviewed reported teamwork was significant and continuity of care was promoted at all times.</p> <p>Maternity: Clients` care plans are client and baby focused, integrated and continuity of care is encouraged for both the mother and the baby. Parenting and mother-craft are included in the goals. Birth plans are developed by the LMC and the client in partnership. Personalised interventions of the client are documented to meet identified needs especially for breastfeeding and recovery from the birth whether from a normal birth or a caesarean section birth requiring post-operative care and management. The maternity notes reviewed were current and up-to-date and signed and dated appropriately.</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>Short term care plans are used for problems that can be resolved within four weeks. The care plans reviewed in all services record interventions that are consistent with the client's assessed needs and desired goals. The family are notified if any changes arise and the care plans are updated to reflect the changes. Observations on the day of the audit indicate clients in all services were receiving care that is appropriate and consistent with the individual client's needs. Care plans were able to be followed easily and were accessible to guide staff as needed.</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>	CI	<p>The activities programme ensures client's individual motivational, recreational and cultural needs are recognised. Each client is assessed by the activities co-ordinator on admission. The clients have the opportunity to maintain interests, choices and activities in a continuing care environment. The activities co-ordinator interviewed reported how the activities programme is developed and implemented for this hospital successfully.</p> <p>The activities programme is planned monthly and displayed on a weekly basis. A copy of the programme is displayed in the activities/dining room notice board. Clients and families can access the information displayed. The activities co-ordinator maintains attendance records. Each resident has their own activities plan which is reviewed six monthly or earlier if required. The co-ordinator is fully aware that clients` participation is voluntary and this is respected. Volunteers 'Pohlen Pals' assist with the activities programme and one on one activities.</p> <p>Clients are encouraged to maintain links with family and the community. Outings are restricted to fortnightly in the community as only a few clients can travel in the van at a time. Special days are</p>

		<p>celebrated and this was evidenced with all the photographs displayed of recent events held. A church service is held weekly. Communion is arranged to meet the needs of the clients.</p> <p>At the time of the audit clients were visibly enjoying the activities in progress and clients reported that they enjoy the variety of planned activities arranged.</p> <p>Maternity: Activities are centred on parenting and breastfeeding education and enhancing mother-craft skills which will be meaningful to the client and partner. There are several goals to endeavour to achieve in the timeframe provided, especially for first time parents. Maternity aides provide full support with breastfeeding as required to ensure the client has a good technique and positioning with breastfeeding the baby. Settling and wrapping is important with the safe sleep project message 'back is best' being promoted at all times. Baby Friendly Hospital Initiative (BFHI) is promoted by staff. Multiparous women often require a good rest and reassurance in managing a new born again.</p>
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	<p>Care plan evaluations occur six monthly or earlier if required. The NP oversees the reviews of the care plans for the hospital level clients. Evaluations are client focused and indicate the degree of achievement or response to supports/interventions and progress towards meeting the set goals. Should a client's needs change or if the client is not responding appropriately to the interventions being delivered then this is discussed with the GP or NP, the resident and the family. Short term care plans are initialised as required, for example for wound care management, PI management, falls prevention, eye infections and other issues.</p> <p>The hospital aides interviewed demonstrated good knowledge of short term care plans and reported that these are identified and information is shared in the handover between shifts. Progress is also discussed on a regular basis.</p> <p>Families reported that they were consulted when staff have any concerns or when there are any changes to the client's condition. The GP interviewed reports appropriate communication is provided by the registered nurses in a timely manner if a client deteriorates or their condition changes or an adverse event occurs.</p> <p>Clients that are for respite care, palliative care, short term GP stays have care plans that are reviewed at each point of contact with the client. Progress records are maintained appropriately.</p> <p>Maternity: Care is evaluated at each point of contact with the client and the baby. Any achievements are acknowledged in the maternity notes regularly. Each entry is documented for the mother or baby, dated and signed with signature and designation of the maternity aide involved. A client plan and checklist are completed for the short term stay (forty eight hours) allocated. Hand over does occur between shifts about clients and their respective care. Additional time can be arranged by the LMC for a client as needed. The maternity aide interviewed is well informed and contacts the LMC promptly if any issues</p>

		<p>arise. Achievement is recognised by a settled baby, lactation establishing, a comfortable and confident client and involvement of the partner if possible.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Clients are provided with options if required to access other health and disability services. There are nine GPs who visit the service regularly and a NP. The GP interviewed explained the after-hours cover for the facility. The GPs arrange any referrals for their clients to specialist medical or surgical services as required. Specialists visit Pohlen Hospital clinics and clients often do not have to be escorted/transported to attend clinics at Waikato Hospital.</p> <p>The GPs provide on call services for acute clients and depending on the GPs and if a bed is available a client can be admitted to the inpatient service for observations or short term if needing to be transferred to the DHB. Centralised services at the hospital include GP, acute, medical, surgical, palliative care, radiology, clinics, podiatry, orthopaedic, mental health, physiotherapy, NP and other services.</p> <p>The GP interviewed reported that appropriate referrals to other health and disability services are well managed. Copies of referrals for inpatient services are retained in the individual client's records.</p> <p>Maternity: Clients can only come to this facility with their lead maternity carer. The service provides primary maternity services only. Any clients requiring to be referred to Waikato Hospital Women's Health Services need to appropriately referred by the client's LMC. For ongoing care if a client is not progressing in labour or a complication is envisaged a referral is arranged promptly by the LMC to the obstetric service at Waikato Hospital. The client and family are kept informed of the referral process.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Policies detail how waste is to be segregated and disposed. The policy content and staff practice aligns with current accepted practice.</p> <p>Chemicals sighted were stored in designated and secure areas. Material safety data sheets and a reference wall chart on actions to take in the event of exposure were sighted for chemicals in use. The washing machine has been fitted with an auto dispenser for laundry products.</p> <p>Appropriate personal protective equipment (PPE) is available on site including disposable gloves, aprons, masks, and face protection. The staff interviewed on this topic detailed what PPE was required to be worn by staff and when, in order to minimise risk of exposure to blood and other body fluids and contaminated items/equipment.</p> <p>Staff advise they would report any inadvertent exposures to hazardous substances and blood and body fluids via the incident reporting system.</p>

Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	PA Low	<p>There is a current building warrant of fitness (expiry 1 September 2016). An external company undertakes performance monitoring and electrical safety checking of clinical equipment. Hot water testing is conducted of all taps and shower rooms/areas every month. The temperatures in some resident areas are above 45 degrees Celsius. The compliance certificate for the medical gas manifold is overdue.</p> <p>The two Pohlen Hospital vehicles used to transport residents to appointments and activities have a current registration and warrant of fitness. Staff driving the vehicle have a current driver's licence and a copy is held in the staff member's file.</p> <p>Grab rails are present in the patient shower and toilet areas. Since the last audit there has been an extensive renovation and refurbishment programme that has been undertaken. This includes new drapery, the facility has been repainted, new flooring, and some new furniture and equipment. Solar panels have been installed to assist with utility services. A six bed unit is in the process of being built. These rooms will be used for the provision of palliative care and other services. The building project has commenced but was not able to be included in this audit due to the stage the building project is at.</p> <p>The bathroom floors have non slip linoleum floor covering. Furniture and fixtures were appropriate to the service setting and client needs. Specialised equipment including air mattresses, low low beds, sensor mats, intravenous infusion pumps and other equipment are available. Clients have personalised their rooms.</p> <p>The clients' bedrooms are of a suitable size. The clients and family members interviewed confirmed the facility for long stay clients is appropriately furnished to create a home like environment.</p> <p>There was a number of external chairs that clients and family can utilise including under the shade of trees. The client bedrooms have an external door outside that can be used to directly access the grounds and garden.</p>
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	FA	<p>Hand basins are present in each client's bedroom with the exception of the four bed observation room where the hand basin is in the bathroom. Waterless hand gel is also readily available for staff and clients throughout the hospital.</p> <p>All bedrooms have an ensuite bathroom with a shower, hand basin and toilet. For the four single bedrooms in the maternity wing, the two delivery rooms and three single rooms in the main hospital the ensuite is per room. Four of the double rooms have their own ensuite in the main hospital wing. For the remaining rooms the ensuite is shared between two bedrooms.</p>

personal hygiene requirements.		<p>There are two additional bathrooms that the public can use. The staff interviewed advised there are more than enough bathroom and shower facilities for the clients' use. Privacy locks are present on bathroom doors where this was checked.</p> <p>There is a separate bathroom for the use of staff. No client or family member interviewed expressed any concerns about the facility or environment.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>There are seven single occupancy rooms and six double occupancy rooms in the hospital area. The two delivery rooms and the four bedrooms in the maternity room are single client occupancy, however the client's partner is also able to stay. The observation area contains four beds.</p> <p>The rooms contained sufficient space for the clients, personal possessions and use of mobility devices if required. Privacy curtains are present between beds in the twin rooms to optimise client privacy. Clients are sighted mobilising independently inside and outside Pohlen Hospital independently and with assistance.</p> <p>The staff interviewed advised there is sufficient space for the clients to mobilise, including when assistance was required. The clients and family members interviewed were very satisfied with the environment</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>There is a large room that is used for the provision of activities, the lounge and a designated area for the dining area that clients and their family or visitors can use. Staff advise there is a separation between activities area and the dining area to make meal times more relaxing and pleasant.</p> <p>There is a quiet room with lounge furniture and tea and coffee making facilities. There are shaded outdoor area with furniture throughout the garden/grounds. The clients and family members interviewed confirmed that there is sufficient space available for clients and support persons to use in addition to the clients' bedrooms.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is</p>	FA	<p>Policies detailed how the cleaning and laundry services are to be provided. The cleaning services are provided by a contracted company until the end of February 2016. After this date cleaning will be undertaken by Pohlen Hospital employees. A copy of the current cleaning contract and specifications was sighted.</p> <p>The household linen is laundered off site by a commercial laundry. Client's personal linen is washed onsite.</p>

		<p>being provided.</p> <p>The clients and family members interviewed confirmed the facility is normally kept clean and tidy and residents' laundry is washed onsite and returned the same day. The client satisfaction with cleaning and laundry services is monitored as a component of the client satisfaction survey. The results verify clients are satisfied with these aspects of service.</p> <p>Audits of the laundry services were undertaken in September 2015 as scheduled on the audit calendar. Cleaning audits occur on a scheduled basis. The most recent audit was in October 2015. The results of these two audits and the follow-up plans were sighted to be implemented.</p> <p>Chemicals are stored in designated secure cupboards. Instructions for managing emergency exposures to chemicals is readily available to staff.</p>
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	<p>The fire evacuation plan has been approved by the New Zealand Fire Service (NZFS) in a letter dated 15 February 1995. A fire evacuation drill was last conducted on 23 November 2015 and the records were sighted. The fire safety features in the building have been upgraded since the last audit.</p> <p>Policy documents and a wall mounted emergency 'flip chart' located in the staff office includes guidance for staff on responding to a range of emergency events, including (but not limited to) earthquake, communication or utility failure and mass casualty events. Staff were provided with training on emergency events as a component of the orientation programme and ongoing education programme. Registered nurses are provided with training on managing obstetric emergencies and infant resuscitation.</p> <p>A review of the staff files and training records verifies the activity coordinator and registered nurses are required to have a current first aid certificate. There is at least one RN on duty at all times.</p> <p>There are supplies available of drinking water, lighting, blankets and other clinical supplies for use in emergency. A sufficient store of dry food goods was also available.</p> <p>A 25000 litre water tank is on site. The water is constantly being used and refilled to ensure in an emergency the water is fresh. There is a diesel generator and fuel on site. An uninterrupted power supply (UPS) is connected to the server and the telephone system. Managers have a mobile phones and there are four 'walky talkies' for internal communication in the event of emergency.</p> <p>Call bells are present in the bathrooms and clients' bedrooms. They alert audibly and a light also illuminates outside the applicable room and on a central call bell panel. Four call bells tested at random were fully functioning and answered by staff promptly.</p> <p>The caregivers interviewed advised the external doors and windows are routinely checked and locked prior to darkness. Security cameras monitor the four patient beds in the observation suite. Clients are asked for written consent for this monitoring to occur. Security camera images are displayed on a</p>

		<p>monitor in the staff office area and the general manager advises are archived electronically for a short period of time.</p> <p>A security company is contracted to undertake external checks of the building every night. The security and police are to be contacted by staff in the event of any security concerns. Staff advise any security events are reported via the incident reporting system and followed up in a timely manner. There is a panic pendant that night staff are able to use to activate help from the security contractors if required. The main door is closed and secured at 5 pm. Family or clients arriving after this time enter via the maternity service entrance, except patients arriving by ambulance who arrive at the ambulance bay near the GP rooms. There is a buzzer on the maternity door that can be used to call for staff.</p> <p>Clients and family members interviewed had no concerns about security or safety.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>There are windows present in all clients' bedrooms. Doors and windows are sighted open during the audit. Heating or cooling is provided when required from wall mounted heat pumps in each client's bedroom. There is a heat pump in the lounge and radiators in the corridor. The radiator heating is automatically turned on if the ambient temperature falls below 14 degrees C.</p> <p>The clients and family members interviewed confirmed the facility was always warm and well ventilated.</p> <p>There is a designated area outside for use by clients and staff who smoke. Staff are encouraged with smoking cessation activities.</p>
<p>Standard 3.1: Infection control management</p> <p>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.</p>	FA	<p>The service has a documented infection control programme which has been developed by an external infection prevention and control consultant in January 2015. The infection control programme minimises and reduces the risk of infections to residents, staff and visitors to the facility. The clinical quality manager has reviewed the infection control programme and documented new objectives for the 2016 year and this was sighted.</p> <p>The clinical quality manager is also the infection control coordinator and holds accountability and responsibility for facilitating the programme. The clinical quality manager monitors for infections by using standardised definitions to identify infections, surveillance, changes in behaviours, monitoring of organisms related to antibiotic use and the monthly surveillance record. Infection control is discussed monthly at each staff meeting, at the quality forum and at the infection control committee meetings. These minutes are readily available for staff in both the meeting minutes' folder and on the staff noticeboard. The clinical quality manager advises there have been no outbreaks of infection since the last audit.</p>

		<p>The clinical and quality manager and a registered nurse interviewed reported that staff are reporting clients suspected of having an infection. Clients with suspected and/or confirmed infections are reported to staff at handover and appropriate care implemented, and this is documented in the client's records including the progress notes. Staff interviewed state that they are alerted to any concerns and are included in the management of reducing and minimising risk of infection through staff meetings, one to one communications, shift handover and in client's documented progress notes.</p> <p>A process is identified in policy for the prevention of exposing providers, clients and visitors from infections. Staff and visitors suffering from infectious diseases are requested not to enter the facility. When outbreaks are identified in the community, specific notices are placed at the entrance saying 'not to visit' the service if the visitor has come in contact with people or services that have outbreaks identified or symptoms. Sanitising hand gel is available and there are adequate hand washing facilities for staff, visitors and clients with hand washing signs noted throughout the facility. Staff and clients are offered annual influenza vaccinations with prior written consent.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The clinical quality manager has the role of infection prevention and control nurse. Infection control issues are discussed at staff and client meetings. The facility has the support of an infection control consultant who is available for advice on infection prevention. Advice can also be sought from different external sources including the laboratory diagnostic services, the general practitioners or the infection prevention and control team at WDHB if required.</p> <p>The infection control coordinator has attended several infection prevention and control seminar days provided by the infection control consultant and attendance records were sighted. The clinical quality manager has also attended other relevant in-service education including wound management, endoscopy reprocessing and palliative care. The registered nurse and hospital aids interviewed demonstrated good knowledge of infection prevention and control processes. On several occasions throughout the audit good hand hygiene practices were observed.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily</p>	FA	<p>An infection control policy sets out the expectations the organisation uses to minimise infections. This is supported by an infection control manual and policies and procedures that have been developed by an external infection prevention and control consultant. The policies are referenced and support specific areas, including antibiotic use, waste management, wound management, blood and body spills, cleaning, disinfection and sterilisation, laundry and standard precautions. Staff were observed demonstrating safe and appropriate infection prevention and control practices.</p>

available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.		
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	<p>The clinical and quality coordinator, registered nurse and hospital aids interviewed were able to verbalise good infection prevention and control awareness. The clinical quality manager attends regular relevant education (refer to standard 3.3 above).</p> <p>Staff are provided with education on infection prevention and control topics during orientation and as a regular component of the in-service education programme. Staff have an awareness of providing additional oral fluids to patients to minimise infection risks during the current hot weather.</p> <p>Education is provided to individual clients on applicable infection prevention activities as detailed on the infection register sighted.</p>
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	<p>All staff providing client care participates in the infection surveillance programme. Monitoring is discussed in various meetings aimed at preventing or reducing infection risks and facilitating the clients' safety. Hospital aids are required to report any suspected infections to the RN for review. The clinical quality manager subsequently completes a monthly surveillance report. The service monitors for a range of infections including, but not limited to, urinary tract infections, respiratory tract infections, skin and wound infections which include cellulitis/tissue/wound infections and scabies, and gastroenteritis. The infection surveillance programme includes clients admitted with infections and those that develop infections after admission. The monthly analysis of the infections includes comparison with the previous month, reason for increase or decrease, trends and actions taken to reduce infections. This information is fed back and discussed in the infection control committee meetings, the quality forum and the staff meetings. The infection rates are also graphed for ease of staff review.</p> <p>Clients and family members interviewed confirmed they are kept informed by staff of any changes in their condition including infections. The general practitioner interviewed also confirms staff communicate in a timely manner about any significant/relevant changes in a client's condition.</p>
Standard 2.1.1: Restraint minimisation Services demonstrate that the	FA	The restraint policy was reviewed. Policies and procedures are available to guide staff in the safe use of restraint when required. Restraint minimisation and safe practice was demonstrated at the time of the audit. Clear definitions of restraint and an enabler are documented.

use of restraint is actively minimised.		<p>The clinical quality manager is the restraint co-ordinator. The coordinator was clear about the process for the one person using an enabler and one client using a restraint. The process of assessment and evaluation of enabler and restraint use is documented. This was also confirmed in interviews with staff. The policy also identified that the use of enablers is voluntary and the least restrictive option to meet the needs of the resident to promote independence and safety.</p> <p>Maternity service: No restraint is used due to the nature of this service.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>A flow chart is also available which outlines the restraint/enabler process. The restraint co-ordinator is supported by the restraint committee which includes the client concerned, their welfare guardian or family advocate, the nurse practitioner or the general practitioner, a cultural advisor where deemed appropriate. This is the approval group for this service. Approval and consent is sought only after alternative options are tried to reduce the risk of harm. Client information is available for the client and/or family/whanau.</p> <p>Approved restraint is identified in policy. The one client currently being restrained is using bed-sides. Processes in place reflect safe use of the restraint. Risks associated with restraint use are minimised and reflected on the individual client's care plan. Regular monitoring occurs and this is evidenced on the monitoring form sighted.</p> <p>The restraint/enabler register is completed and was reviewed and all relevant information was recorded. With the introduction of low low beds throughout the facility this has significantly reduced falls and use of restraint/enablers.</p> <p>Ongoing review of restraint/enabler use occurs monthly by the restraint committee and minutes of meetings were sighted. The minutes are presented at the quality meetings. Any trends or concerns are discussed.</p> <p>All staff receive education on restraint minimisation and safe practice, de-escalation techniques, risk assessment, client safety, human rights legislation and the Code at orientation and this is provided annually. A work book was sighted in all staff records reviewed. Staff interviewed confirmed their understanding of restraint and use of the restraint care plan.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in</p>	FA	<p>There is a comprehensive assessment completed by the registered nurses as part of the interRAI process on admission vice for clients on the residential aged care agreement. Another assessment for clients who may require enabler/restraint minimisation was reviewed. This form is used also for all re-assessments. Full discussion occurs with the client/family/representative the GP/PN and the restraint</p>

relation to use of restraint.		<p>co-ordinator. Any risks are identified and discussed with the GP/NP and highlighted on the nursing care plan. Any challenging behaviour and de-escalation management is clearly documented on the care plan. Cultural needs are addressed and personal cares are documented if required on the individual client's care plan as well as the two hourly monitoring requirements including change of positions and time for releasing the restraint.</p>
<p>Standard 2.2.3: Safe Restraint Use Services use restraint safely</p>	FA	<p>Restraint is used as a last resort only to maintain safety of clients, service providers and others. Full assessments are performed prior to instigating any form of restraint. The restraint co-ordinator is a registered nurse and the clinical quality manager. The environment is always deemed appropriate and safe for a restraint to be instigated.</p> <p>Each episode of restraint is documented on the monitoring forms to provide an accurate account for the indication for use, intervention, duration and the outcome. The restraint register is maintained and kept in the ward nurses' station. Monitoring occurs two hourly and is accurately documented on the chart reviewed. Evaluation occurs monthly and six monthly as part of the multidisciplinary review.</p> <p>Staff interviewed were fully informed on all aspects of restraint minimisation and safe practice. Restraint management is closely linked to the falls prevention programme undertaken by the service. Restraint is discussed at the monthly restraint meetings and evidenced in the minutes of meetings reviewed.</p>
<p>Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.</p>	FA	<p>The evaluations occur monthly by the restraint committee and six monthly when the multidisciplinary meeting occurs. The impact the restraint has had on the client is monitored as well as the observations and monitoring requirements to maintain the safety of the client. All requirements of this criterion are considered during the review process and are discussed at the restraint meeting held on a monthly basis. The outcome as discussed with the restraint co-ordinator is the focus for the client ensuring safety and care is maximised and not compromised in anyway.</p> <p>Policies and procedures are reviewed annually. The individual client's nursing care plan is reviewed six monthly or more often if required. The education plan for the year was reviewed and restraint minimisation and safe practice is included.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the</p>	FA	<p>The meeting minutes for four months of restraint meetings were reviewed. The meeting agenda included any matters arising from the previous meeting, review of restraint status, restraints discontinued, any new restraints if any is use, monitoring and general business. Any trends are discussed.</p>

monitoring and quality review of their use of restraint.		Restraint use has decreased over the last year. The falls prevention programme is linked to restraint minimisation and safe practice and education is as per the training schedule which is reviewed annually. An annual report is prepared for the Pohlen Trust Board. The policies and procedures have been reviewed 2015 and are current and up-to-date.
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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 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Low	Staff ongoing education is well planned and provided. The education is appropriate to the service setting and includes in-service education on site as well as access to external education. Records of attendance are maintained. The hospital aids are encouraged to complete an industry approved qualification. There are six staff who have completed one or more industry approved qualification. An additional six staff are in the process. Records are not available to demonstrate the cook has completed a food safety training programme. ‘In house’ food safety training has been provided to other members of the catering team. All staff participate in training as part of the ‘baby friendly hospital’ programme.	Records are not available to demonstrate the cook has completed an approved food safety training programme.	Ensure records are available to demonstrate that catering staff have completed an appropriate food safety training programme. 180 days
Criterion 1.4.2.1 All buildings, plant, and equipment comply with	PA Low	Staff are required to report any maintenance issues to a designated staff member verbally or by completion of a template form. Records are maintained of all requests and the follow-up action and communications undertaken. Applicable items are recorded on the facility hazard register until remedial action has been successfully completed.	The water temperature in identified patient bathrooms	Ensure hot water in patient care areas is maintained at the required temperature.

	<p>legislation.</p> <p>Monitoring occurs to ensure requested maintenance activities are undertaken in a timely manner with the current exception of hot water temperature monitoring. Hot water testing is conducted of all taps and shower rooms/areas every month and the records for the last four months were sighted. The temperatures in some resident areas are consistently above 45 degrees Celsius. The Pohlen Hospital policy related to water temperature monitoring was reviewed and updated during audit to provide more clarity for staff on the process required if the water temperatures are tested and are elevated. The plumbing contractor verifies being notified of the increased hot water temperatures.</p> <p>There is a current building warrant of fitness (expiry 1 September 2016). An external company undertakes performance monitoring and electrical safety checking of clinical equipment. Electrical equipment checked at random have a current electrical testing and tag label. Clinical equipment has undergone performance monitoring testing and clinical calibration in August 2015.</p> <p>The medical gas manifold is kept secure. The compliance certificate reviewed is overdue. The medical gas supplier was contacted during audit in regards to this and identified they would attend within 24 hours of the audit to address this.</p>	<p>is above 45 degrees Celsius.</p> <p>The medical gas manifold is overdue the review for compliance.</p>	<p>Ensure the medical gas manifold is included in the routine maintenance/service review programme.</p> <p>180 days</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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.3.4.2 The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.	CI	Client records reviewed evidenced that the goals of clients are realistic and are identified through the comprehensive assessment processes implemented on admission. The assessments are the basis of service delivery and developing the care plans and subsequent care. Additional assessment tools utilised for all clients have highlighted special needs of residents such as falls risk. Increased education of staff and in the community has had excellent results to improve this aspect of service delivery and to meet individual goals for clients and increase public awareness at the same time. Links with restraint minimisation and safe practice are observed. Red labels on the door of clients' rooms highlight to staff the falls risk to the client and a red border is placed on the daily living plan above each bed if relevant. A post falls assessment form has been developed and implemented.	A continuous improvement rating is awarded as the comprehensive assessment and the falls prevention project has had significant impact on the reduction of falls in this service and in the community. Data was collected through the incident/accident statistics collated and graphed. A time frame of six months was set and responsibilities of staff were outlined. The outcome far exceeded the intended objective to reduce falls by 50% by another 13% with a total of 63% reduction observed. The falls had predominantly occurred in palliative care clients accessing the service. This information has also been forwarded to the team involved in planning the prospective palliative care wing so that consideration will go into the planning of the new wing which is under construction. Interventions identified in the project included use of low beds and floor lighting. With the increased education all staff are able to identify clients more at risk and safety has been promoted.

Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.	CI	<p>The activities programme is developed and implemented to maintain the strengths and interests that are meaningful to the clients. Due to the high level of hospital level clients in this service and clients from various other service streams accessing the service, the activities programme has to be designed to meet all needs of all clients individually. The involvement of trained volunteers from the community has improved outcomes and huge benefits have been gained such as clients with limited family/whanau have regular contact with a familiar visitor. Extra help and assistance allows increased participation in community outings and more personal one on one contact. From the activities co-ordinators perspective clients can now have more choices of activities as more assistance is available. Also the introduction of volunteers with more skills is adding more variety to the programme.</p>	<p>A continuous improvement rating is awarded for the significant changes in the activities programme which far exceeds the expectations of the previous activities programme. The new project has increased community awareness and interest in the hospital and has been valuable for the service being able to build a strong volunteer team culture and report positively on the benefits of having the volunteers at the hospital. Six monthly feedback forms are developed and implemented to provide the volunteers with opportunity to identify any concerns. The benefits for the clients has been significant with regular community visitors and one on one activities needs being extended and managed more effectively.</p>

End of the report.