

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: 18 February 2019	End date: 19 February 2019
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:	27	



Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Pohlen Hospital provides rest home and hospital level care (medical and geriatric) and hospital services (surgical and maternity) for up to 33 clients. The service is operated by a charitable trust and managed by a general manager and a clinical quality manager. Since the last surveillance audit there has been an increased uptake of the palliative service and use of hospice beds and a significant decrease in the provision of surgical hospital services. All other areas of service provision remained unchanged. Clients and families are very satisfied with the personalised model and delivery of care.

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

This audit has resulted in continuous improvement ratings in the areas of service development for Maori, advance care planning and food and nutrition for maternity clients and identified areas requiring improvement relating to staff appraisals, documentation of corrective action processes and an area of medicines management.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Residents/clients and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Services are provided that support personal privacy, independence, individuality and dignity. Staff interact with residents/clients in a respectful manner.

Open communication is promoted between clients/residents of the service, and confirmed to be effective. There is access to interpreting services if required. Staff provide residents/clients and families with the information they need to make informed choices and give consent.

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

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

All issues raised as concerns by staff, residents/clients and families are resolved promptly. There is a complaints process and policy that is understood by all.

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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Strategic, operational and quality and risk plans identify the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body is regular, detailed and effective. An experienced and suitably qualified person manages the facility.

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

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes individual performance review. Staffing levels and skill mix meet the changing needs of clients/residents.

Clients'/residents' information is accurately recorded, securely stored and not accessible to unauthorised people.

Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/client/family.

The multidisciplinary team, including a registered nurse and general practitioner, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed on a regular and timely basis. Residents are referred or transferred to other health services as required.

The lead maternity care midwives are responsible for their clients and access clients daily when in the maternity annexe. Maternity healthcare assistants provide care and support to clients with breast feeding and baby cares. Parental education is provided at every opportunity.

There is an activity programme which provides and maintains links with the community.

Medicines are managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents/clients with special needs catered for. Residents/clients verified satisfaction with meals.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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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. Equipment for daily use and medical equipment have been tested and calibrated as required. Appropriate security processes are in place and includes monitoring by an external contractor.

The layout of the facility is fit for purpose with all rooms having access to the gardens on the property. There are adequate amenities and staff ensure the area is free of clutter to manage the safe mobilisation of all clients.

Cleaning is provided by employed staff. Clients' personal clothing is laundered by staff. Hospital linen is processed by an external contractor.

Policies and procedures are documented to assist staff with the management of emergencies. These are easily accessed and known to staff. There is a fire evacuation plan and routine fire drills. Staff receive training in first aid for adults and new-borns. There are sufficient supplies to safely manage the care of the clients in the event of emergency.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The organisation has implemented policies and procedures that support the minimisation of restraint. No residents were using an enabler at the time of the audit. Use of enablers is voluntary for the safety of residents in response to individual requests. Two restraints were in use. A comprehensive assessment, approval and monitoring process with regular review is described in policy. Staff interviewed demonstrated knowledge and understanding of the restraint and enabler processes. Education is provided to staff.

Infection prevention and control

<p>Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.</p>		<p>Standards applicable to this service fully attained.</p>
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The infection prevention and control programme, led by a two-member team of registered nurses, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

Staff demonstrated good principles and practice around infection control, confirmed access to policy and the provision of education. Policies were current and included good practice requirements.

Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action is taken as and when required.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	47	0	3	0	0	0
Criteria	3	97	0	3	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	The service has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records. This included the maternity aides who are employed to cover the maternity unit. The Matamata midwives interviewed were able to describe the responsibilities of a Lead Maternity Carer (LMC) in relation to the Code.
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	Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provided relevant guidance to staff. Clinical files reviewed showed that informed consent has been gained appropriately using the organisation's standard consent form. Advance care planning is discussed with the GP. The resuscitation plan and discussions are now recorded on the newly implemented form (blue) sighted. Establishing and documenting enduring power of attorney (EPOA) requirements and processes for residents unable to consent is defined and documented. EPOA forms completed are kept in the front of the resident's record. Staff were observed to gain consent for day to day care.

informed consent.		The maternity aide and midwives interviewed understood about the consent for the woman to retain the whenua/placenta or to have this disposed of after the birth.
<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	During the admission process, all residents and new mothers in the annexe (maternity unit) are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service were also displayed and available in the facility. Family members and residents/clients spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. There is information at the hospital reception and the maternity unit identifying the local advocate based in the community and their contact details.
<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>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment. The clinical quality manager interviewed stated that there are unrestricted visiting hours for family and close friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.</p> <p>In the maternity unit visitors are welcome during the visiting hours. Partners and/or support person are able to stay and provide support if they wish. A support person is discussed with the midwife at about thirty-six (36) weeks gestation. Clients interviewed confirm they have access to visitors of their choice. Clients are provided with a wide range of pamphlets which identify the support services available within the community.</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/concerns/issues policy outlines the requirements of Right 10 of the Code. The process is easy to follow and this information is provided to all consumers and families on admission. Clients/residents and their families were able to describe the process they would use if unhappy with any aspect of the service. The facility has a complaints' register. No formal complaints have been logged since the last audit. The preferred and well used operational method is to meet with all users as soon as a concern is voiced. The issue of concern is discussed and remedial actions put in place as needed. This is documented and information trended and discussed at quality meetings. Staff confirmed this practice. Resident meeting minutes, feedback forms and staff meeting minutes verified a process that includes discussion of concerns and follow up.</p> <p>The general manager (GM) and clinical quality manager (CQM) include a daily walk about in their routine meeting with patients, residents and their family members. Long term clients are invited to an annual meeting with their families and volunteers facilitate regular resident and family meetings. The</p>

		<p>GM and CQM are responsible for the processing of concerns or complaints and follow through of actions taken. They confirmed their approach of meeting with clients daily mitigates many issues which may have otherwise resulted in formal complaints.</p> <p>There have been no complaints received from external sources since the previous audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Patients/residents interviewed report being made aware of the Code and the Nationwide Health and Disability Advocacy Service through the registered nurses explaining this on admission and/or the women in the maternity service stated that the midwives explained this at the first point of contact at their antenatal clinic. A pamphlet is provided in the service information pack. The Code is displayed throughout or services along with pamphlets and how to make a complaint and feedback forms were accessible.</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>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff were observed to maintain privacy throughout the audit. All clients in the maternity unit have a private room. In the end of life (palliative care) wing there are single rooms, and in the hospital, there is a combination of single and double rooms with curtains between the bed spaces. The clinical quality manager interviewed stated that at the time of admission consent is verbally discussed and obtained for the sharing of a room.</p> <p>Residents are encouraged to maintain their independence by attending community activities and participation in clubs of their choosing. Care plans included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>All maternity clients and their family/whanau have access to a service that promotes independence, involvement in decision making, respect and promotes confidence in caring for their new baby. The maternity aides interviewed confirmed an understanding of the client's right to privacy. Support is provided in a manner that is responsive to clients' needs and promotes a healthy community. The Matamata midwives are actively working with the community to reduce the onset and consequence of family violence against women. The midwives receive education through the New Zealand College of Midwives every three years.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any</p>

		signs. Education on abuse and neglect was confirmed to occur during orientation and annually.
<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 individual and cultural, values and beliefs.</p>	FA	<p>Staff support residents/clients in the service who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau. The clinical quality manager interviewed reported that there was one resident who affiliated with their Maori culture at the time of audit. Six staff identify as Maori. There are no barriers in supporting residents/clients who are admitted to the facility who identify as Māori. There is a current Māori health plan, however all values and beliefs are acknowledged and integrated into long-term care plans with input from cultural advisers within the local community as required. Guidance on tikanga best practice is available. A Maori health advisor who is a board member for this organisation is available and was interviewed.</p> <p>The Pohlen maternity unit provides services which respect and acknowledge the needs of Maori and the cultural needs of birthing wahine. Providing culturally appropriate services is seen as supporting a healthy community. Ethnicity is documented on the booking form. Any identified cultural needs are documented in the midwifery notes if identified. Information about the Code is provided in te reo Maori. The manager, midwives, clinical quality manager and staff demonstrated a commitment to whanau wellbeing by maintaining the organisation's 'Baby friendly hospital initiative' status (BFHI) which expires in 2021 and ensures all staff receive adequate training.</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>Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident's personal preferences required interventions and special needs were included in care plans reviewed. Interviews with residents and families confirmed that individual needs are being meet.</p> <p>The midwives contracted by Pohlen Hospital are required to indicate (at the booking stage) if an interpreter is required. Clients are asked to identify any special cultural requirements. The client and partner interviewed confirmed they received services appropriate to their needs. Individual values and family/whanau beliefs were acknowledged and supported.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or</p>	FA	<p>Residents/clients and family members interviewed stated that residents/clients were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. All registered nurses have records of completion of the required training on professional boundaries. Midwives interviewed stated that postnatal staff are aware of their professional boundaries and always</p>

other exploitation.		work within their scope of practice. Performance appraisals sighted included feedback from peers and clients regarding the Code of conduct and boundaries. There are adequate processes in place to ensure discrimination does not occur. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	<p>The service encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, the hospice/palliative care team, diabetes nurse specialist, wound care specialist, psycho-geriatrician and mental health services for older persons, and education of staff. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice. Other examples of good practice observed during the audit included day to day discussions between residents and staff.</p> <p>The Baby Friendly Hospital Initiative (BFHI) policy and procedure manual includes the organisation's breastfeeding policy, standards, principles of the Treaty of Waitangi, education, rooming-in, 'skin to skin', bed sharing, breast care, discharge, artificial feeding for mothers who feed their babies milk substitutes when medically indicated. Infant formula storage and recording, feeding with infant formula as medically indicated are clear for staff to follow and implement as needed. There was also a rooming in policy which clearly defined the reason and timeframes for removing baby from the mother's room. All staff and the maternity aides have completed BFHI training. Training was in line with the New Zealand Breastfeeding recommendations.</p>
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	<p>Residents and family members stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff knew how to access interpreter services, although reported this was rarely required due to all residents able to speak English. The staff provide support to residents in regard to mobility and daily activities of living.</p> <p>In this primary birthing maternity unit clients interviewed reported they have sufficient time and support for discussions to occur. One on one support is provided by the maternity aides and the midwives visit daily. Discussions occurs in private rooms. The service is achieving positive outcomes for clients and a</p>

		range of local initiatives have improved breastfeeding outcomes for clients. Processes which support open communication.
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>The strategic plan is developed ever three years and operational business plans are reviewed annually. Both documents were current and outline the purpose, values, scope, direction and goals of the organisation. The documents described longer-term objectives with key deliverables that are part of the ongoing and annual reporting and review. The board meets monthly and a sample of the general manager's reports showed information presented systematically against set objectives. The detail of information included explanations, summaries and graphs providing an adequate overview of organisational performance. Emerging risks, issues, feedback and activities are included in these reports. The general manager and board member interviewed discussed current issues and strategies that aligned with documented plans. The board member acknowledges the depth of information received and engagement of senior management with the board and its vision.</p> <p>The service is managed by a general manager who holds relevant qualifications and has been in the role for more than two years. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The general manager understands regulatory and reporting requirements, is knowledgeable about the sector and unique model of service delivery at Pohlen Hospital. Currency of information is managed through attendance at conferences, local district health board meetings, liaison with community groups, the Pohlen Foundation Trust who assist in fundraising, local iwi groups and maintaining close ties with other providers in the sector.</p> <p>The service holds contracts with the DHB for Age Residential Related Care (ARRC), Long Term Support - Chronic Health Conditions (LTS-CHC), Residential Respite which is inclusive of palliative care and post-acute convalescent care (PACC), Primary Care in-patient Services (General Practitioner clients) and Primary Maternity Care. Twenty-seven clients were receiving care on the first morning of audit. Of these, five were receiving rest home care, twelve hospital care, six palliative care, two under PACC contracts, one under an Accident Compensation Corporation contract, and there was one general practitioner patient. There were no women in the maternity suite on the morning of day one. A mother and baby were transferred in for post-natal care on the evening of day one.</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</p>	FA	<p>When the general manager is absent, the clinical quality manager carries out all the required duties under delegated authority. During absences of key clinical staff, the clinical management is overseen by the clinical quality manager and/or the general manager both of whom are registered nurses and experienced in the sector. The management team reported that this arrangement works well due to the opportunity it provides to work alongside staff and clients. Staff agree with this model and reported that</p>

<p>and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>		<p>the current arrangements work well.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>PA Low</p>	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. The components of the quality system include the reporting and management of incidents and concerns/complaints, planned audit activities, a regular patient satisfaction survey, identification of hazards and risk, staff and stakeholder satisfaction, health and safety components, monitoring of infections and outcomes.</p> <p>There is a framework of meetings that cover all areas of practice, staff and clients. The information and outcomes from all groups are listed at a six weekly quality and risk meeting. Meeting minutes reviewed confirmed regular review and analysis of data and reporting. Relevant corrective actions are developed and implemented to address any shortfalls. Information and outcomes are shared with relevant staff and clients. The service offers clients a number of opportunities to provide feedback - both written and verbal. Evidence of feedback forms over the last year and a collation of verbal feedback from clients attest to a high degree of satisfaction with the services provided. Clients/residents reported that staff and management are interested in feedback and communication is consistently provided by all staff. Examples were sighted of management involving family and advocates to address issues of concern. See example in 1.3.13 related to the improvement of food provisions for maternity clients.</p> <p>Management team members and staff are confident with reporting, dealing with issues promptly, developing corrective actions and communication. Minutes of meetings evidenced this process works well. It is not immediately clear from documentation sighted what issues remain current and those closed out. The need for clear documentation of the corrective action process is an area raised for improvement.</p> <p>Service providers reported over the last year there has been more representation of staff at the individual forums and staff involvement in leading project work and improvements. Staff also reported several 'healthy staff' initiatives provided by the management to support the culture and health of staff.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The two managers and board member interviewed described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements. A new</p>

		workplace wellness programme WorkWell has been adopted by the organisation and staff teams are underway with the review and development of services.
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated along with data of issues and concerns analysed and reported to staff, clients/residents and the board.</p> <p>The management team described essential notification reporting requirements. They advised there have been two notifications of significant events made to the Ministry of Health, that have included the involvement of police, one last year and one recently during the audit. Both incidents were present in adverse event documentation reviewed.</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>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of eight staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Two recently recruited staff were interviewed and reported that the orientation process was organised appropriately, unhurried and well-supported by staff and management. They felt it prepared them well for their role. The staff records reviewed showed documentation of completed orientation and a catch-up reviews by the management team.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Care staff have completed a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements. Over the last year the organisation has lost two registered nurses who undertake interRAI assessments and have recently employed one nurse with that competency. There is a current plan to train all registered nurses in this competency to avoid a repeat of the previous situation. Records reviewed demonstrated a clear system of recording staff competencies, ongoing education and educational needs. Staff reported having a number of opportunities to train and learn new skills. The management team supports staff to learn the skills and competencies required to work across the different areas of service offered.</p> <p>Whilst there is a schedule of annual performance appraisals the completion of these is an area needing</p>

		improvement.
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). Electronic human resources management software is used in conjunction with oversight of rostering by the management team to efficiently manage safe staffing. The facility adjusts staffing levels to meet the changing needs of clients. Examples of these adjustments were sighted alongside the increase in the number of palliative care clients. Additional care staff are placed on duty depending on the acuity and care needs of these clients.</p> <p>An afterhours on call roster is in place, managed by the general manager and clinical quality manager with the recent addition of a senior staff nurse being trialled in this role. Staff reported that good access to advice is available when needed. The co-located GP practice continues their support of Pohlen Hospital. Care staff (Health care assistants and enrolled nurses) reported there were adequate staff available to complete the work allocated to them. Clients/residents and family members interviewed supported this. Observations and review of three four-week roster cycles confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. All staff have first aid certification and there is 24 hour/seven days a week (24//7) RN coverage at Pohlen Hospital. General Practitioner patients are visited at least once daily by their GP.</p> <p>Midwives are on call 24 hours/seven days a week. They are supported by a health care assistant / enrolled nurse (EN) and RN from the ward when the LMC's are not onsite.</p> <p>The service has dedicated cleaning, laundry and kitchen staff seven days a week. There are vacancies in the cleaning and laundry complement of staff and a recruitment process is underway. One diversional therapist covers the weeks activities.</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>All necessary demographics, personal, clinical and health information was fully completed in the residents' records sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. The GP patients under the agreement have separate records maintained by their GP or the nurse practitioner. The nurse practitioner is no longer working for the medical practice which is a recent change for the service. InterRAI assessment information is entered into Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable. The Matamata midwives have introduced a booklet for all maternity notes for the mother and baby covering all stages of service delivery. While the records are contained in the same booklet the mother and baby notes are separate.</p> <p>Archived records are held securely on site and are readily retrievable using a filing system. The</p>

		administration staff are responsible for the management of the archived medical records. Patients' records are held for the required period. No personal or private resident/patient information was on public display during the audit.
<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>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. The organisation seeks updated information from the NASC (Disability Support Link – DSL) and the GP for residents accessing respite care. The GP residents admitted are either referred by the DHB or by the GPs in the community. Full information is required from either source prior to admission. Criteria for entry is documented and the GPs visit their residents while in the service and all visits are documented.</p> <p>Notification of imminent entry to the maternity unit is given to the facility by the midwife. The maternity aide prepares the birthing unit and appropriate postnatal room for the client. The criteria for entry for the primary maternity service is that clients are low risk and meet the requirements of Section 88. This is the responsibility of the midwife prior to completing the booking form for the client.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic details and assessments. Residents' files had a signed admission agreement and/or a copy of the enduring power of attorney documents in accordance with contractual requirements.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The clinical quality manager explained the process and the transfer form is completed as required. There is open communication between all services, the resident and the family/whānau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient transferring to the outpatient service for the day of audit showed good communication between the facility, acute setting, resident and family. Family of the resident reported being kept well informed during the transfer of their relative. The patient was being transported by the ambulance service.</p> <p>The midwife interviewed stated that clients were discharged with appropriate care and education to ensure a safe transition home. A discharge checklist is used for the mother and baby to ensure the discharge was planned and coordinated in a safe manner. An external transfer in an emergency is managed efficiently as required with the staff assisting as needed. If a woman is transferred to the DHB</p>

		a transfer form is completed with all relevant client information. A record is documented in the maternity register maintained.
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	PA Low	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management (using a paper- based system) was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided as required.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries. There were no controlled drugs stored in the maternity unit. Midwives prescribed medications within their scope of practice. Minimal stocks were stored in the maternity service.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review is consistently recorded on the medicine chart. Standing orders are used, are current and comply with guidelines and are reviewed annually in October signed and dated by the general practitioners. There was evidence of transcribing by a registered nurse in records randomly sampled; this is an area requiring improvement. A specimen signature list of all prescribers and administrators of medicines is available in front of the medication record folders reviewed.</p> <p>There was one resident who was self-administering an oral medication at the time of audit. Appropriate processes were being followed. There is an implemented process for comprehensive analysis of any medication errors.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p>	FA	<p>The food service is provided on site by one of three cooks and a kitchen team and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns. The</p>

<p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>current menu was last reviewed annually as per service policy by a qualified dietitian in May 2018. Recommendations made at the time have been implemented.</p> <p>All aspects of food procurement, production, preparation, transportation, delivery and disposal comply with current legislation and guidelines. Food was observed during the audit at lunchtime. The cook interviewed explained the changes that have occurred in relation to feed-back received from women accessing the maternity unit. Women interviewed stated that the choices and availability of additional food as required was accessible to women. Breakfast is served early but changes are to be implemented to set up breakfast over a two-hour period and women can self-serve from a variety of foods provided when they are ready to do so. Choices of food and a menu were reviewed. A continuous improvement has been given for the improvements initiated to the food service for clients receiving primary maternity services.</p> <p>The service operates with an approved food safety plan and registration issued by the Waikato Council which is next due to expire 13 February 2020. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cook has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p>
<p>Standard 1.3.2: 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>If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local DSL (Disability Support Link) needs assessment co-ordination team is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to DSL is made and a new placement found, in consultation with the resident and whānau/family. There is a clause in the access agreement related to when a resident's placement can be terminated.</p> <p>The midwives are responsible for ensuring their clients are appropriate to labour and birth in a primary birthing facility as per the Section 88 guidelines. This is also the case when a woman and her baby is transferring to this facility from the DHB for postnatal care and management.</p>

<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>Information is documented using validated nursing assessment tools, such as pain scale, falls risk, skin integrity, nutritional screening and depression scale, as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. Residents have interRAI assessments completed by one of the two trained interRAI assessors on site. Residents and families confirmed their involvement in the assessment process.</p> <p>The midwives (6) are responsible for all assessments of the mother and baby through all stages of service delivery. Care plans for the mother and/or the baby were developed to reflect the assessment findings.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed.</p> <p>Care plans evidenced service integration with progress notes, activities notes, nursing, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Residents all have a social assessment completed by the activities coordinator. Residents and families reported participation in the development and ongoing evaluation of care plans.</p> <p>The maternity records reviewed contained the daily assessments completed by the midwives and described the interventions required to achieve the documented outcomes for the mother and baby.</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>	<p>FA</p>	<p>Residents' files were reviewed at the time of audit and included residents receiving palliative care and GP medical care. Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP practice is on site at Pohlen Hospital. The residents admitted to the facility have continued to stay with one of the GP's in the practice that supported them when living in the community. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is acceptable. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs. Monitoring occurs if a patient is presenting with challenging behaviour. The form was sighted. Activities are provided for all residents.</p> <p>For the maternity service, the maternity assistant interviewed confirmed that care is provided as outlined in the documentation reviewed for the mother and baby. The partner interviewed felt they had been</p>

		involved in their care planning and delivery process.
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The activities programme is provided by an activities co-ordinator who has been in this role for one year. The activities coordinator is an experienced health care assistant and has worked at the facility for seven years and is enrolled to complete the relevant training required. The activities co-ordinator is supported by volunteers. A designated volunteer van driver has a current first aid certificate. Networking with other residential aged care facilities is encouraged.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities that residents are partaking in are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated monthly by the activities co-ordinator. A wide range of activities are planned.</p> <p>Activities reflected residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Residents and families/whanau are involved in evaluating and improving the programme through residents' meetings. Residents and families interviewed confirmed they find the programme very interactive in the rest home. Hospital level patients also enjoy the activities in the group or one on one activities are provided. The activities co-ordinator maintains the attendance records and progress records are updated regularly. A review occurs when the interRAI re-assessments are completed and when the registered nurses update the care plans input is sought from the activities coordinator.</p> <p>There is a television in the main lounge of the maternity unit. DVDs are available that can be used to provide educational material for new parents. Pamphlets and resources are available throughout the unit for parents to access. The maternity assistants can demonstrate baby bathing, safe sleeping and techniques and positioning for promoting successful breastfeeding. The woman interviewed was pleased to have some additional support and refresher of new born cares for her baby and for breastfeeding.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short-term care plans being consistently reviewed, and progress evaluated as clinically indicated were noted for infections and wounds. When necessary, and for unresolved problems, long term care plans are added to and updated. Residents</p>

		<p>and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes. The resuscitation status is reviewed along with the six-monthly multidisciplinary team meetings.</p> <p>All clinical records reviewed in the maternity unit confirmed evaluation of service delivery plans took place daily by the midwife. This included evaluation of the baby to ensure new-born behaviour was observed. Ongoing evaluations occurred with each point of contact with the mother and the baby. Discussions occurred between the maternity assistant and the midwife.</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>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a GP practice on site residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP or clinical quality manager sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to a speech language therapist, mental health services for the older person, and geriatrician. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately by the GP or on call GP if after hours.</p> <p>Clients admitted to the maternity unit for postnatal care stay approximately forty-eight hours. For clients that required a longer stay this was arranged following discussion with the client and the midwife. Women can access routine scans onsite. Emergency scans are available at Waikato maternity services and women are followed through by the obstetrician on duty. A referral is required to the DHB should a woman be in labour and need to transfer for one reason or another. The Section 88 referral guidelines are used appropriately as required and a transfer form is completed. The midwives transfer the care of the client to the DHB.</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>There are documented processes for the management of waste and infectious and hazardous substances. Staff are aware of the safety requirements when handling waste and hazardous substances. Personal protective equipment is available in a number of areas in the wards and on the property. Staff were observed to use this equipment where required. Gases are securely stored and safety monitoring systems are in place. An external company is contracted to supply and manage cleaning products. Material safety data sheets and spill kits were available where chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur. Appropriate signage is displayed in all areas on the property. The incident reporting system is used by staff to report all adverse events related to hazardous material, waste and blood or body fluid incidents.</p>

<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>A current building warrant of fitness (expiry date September 2019) is publicly displayed.</p> <p>Appropriate systems are in place to ensure the physical environment for aged care residents, palliative care patients, mothers, babies and families are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment was current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. The environment in all areas was hazard free. Grab rails were present in the residential areas and in the toilet and shower rooms. Staff were observed to put equipment away after use in pre-allocated storage areas.</p> <p>External areas are safely maintained and were appropriate to the consumer groups and setting. All rooms have access to the well-maintained gardens. In response to client and staff feedback in the maternity area, the facility managers are in the process of refurbishing a secure area by the post-natal rooms where younger children can play.</p> <p>Consumers of the service interviewed were able to describe how they would report a need for any repairs or maintenance. Residents' meeting minutes confirmed this is discussed and actions are taken by staff where needed. The feedback on the environment was positive.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. These are a mix of ensuites in single rooms, a shared facility used by two rooms and another shared facility used by a four bedded area. Additionally, there is one room that has the toilet and shower located within easy access. All rooms have a hand basin installed. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence.</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>	<p>FA</p>	<p>In the aged care residential area and the maternity area there are single rooms. The space used for patients needing medical and/or convalescent care is a four bedded area. Each bedroom is of a good size to allow for personal effects and the use of personal and medical equipment. Residents and staff have adequate space to move safely in these rooms. Rooms are personalised with furnishings, photos and other personal items displayed. Staff and residents are satisfied with the rooms and space available.</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>Communal areas are available for all clients of the service. There is a specified dining and activity room which is spacious and allows residents to engage in activity or sit quietly. This area is easily accessed by all residents, staff and family members. Residents can also access areas for privacy, if required. Furniture is appropriate to the setting and clients' needs.</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 being provided.</p>	FA	<p>Laundry for personal items is undertaken onsite. Other items are managed by a contracted provider. There is a small designated space with two rooms used as the laundry area. The maintenance manager with oversight of the laundry and cleaning demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents do not have concerns with relation to the general management of their clothes.</p> <p>There is a small designated team who are trained in their roles to manage both the cleaning and laundry. There are current vacancies in this area and a process is underway to recruit more staff. The environment was noted to be clean and maintained. Both the cleaning and laundry processes are monitored via monthly audits. Chemicals were stored in a secure area and appropriately labelled. There is a system of cleaning which includes the use of coloured cloths with different textures for different areas. Where cleaning solutions were decanted, the holding receptacles were labelled.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>There are policies and guidelines for emergency planning, preparation and response. These are located by the front desk. Staff interviewed described the six-monthly fire evacuation drills and other procedures to follow in the event of a civil defence emergency or disaster. The most recent fire evacuation drill was on the 17th of December 2018 with a copy sent to the New Zealand Fire Service. The orientation programme includes fire and security training.</p> <p>There were adequate supplies for use in the event of a civil defence emergency, including food, water and communication devices. These were assessed as being adequate for the number of clients. The quantity of water stored in the storage tank on the property meets the local city council requirements for quantity per person. There is a generator on site and emergency lighting is regularly tested.</p> <p>Registered nurses have a current first aid certificate. At least one RN is rostered on duty at all times. Registered nurses are also provided with training on managing obstetric emergencies and infant</p>

		<p>resuscitation.</p> <p>Call bells are available in all areas of the facility. These alert staff to residents requiring assistance and are routinely tested. Feedback received from clients and staff confirmed there have been no reported issues with staff response to call bells.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and a security company checks the premises at night. There is one designated entry and exit point after hours.</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>All bedrooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows and doors. Heating is provided by panel heaters and wall mounted heat pumps in residents' rooms and in the communal areas. Areas were at a comfortable temperature and well ventilated. Staff, clients and families confirmed that comfortable temperatures are maintained in all seasons.</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 implements an infection prevention and control (IPC) programme to minimise the risk of infection to clients, staff and visitors. The programme is guided by comprehensive and current infection control documents, with input from an external infection control consultancy service. Pohlen Hospital has recently subscribed to the online portal for the consultancy service allowing access to updates and updated policy and procedural documents. The infection control programme and documents are reviewed annually.</p> <p>The clinical quality manager is the designated IPC coordinator, whose role and responsibilities are defined in a job description. A second registered nurse has been assigned to support this role in a part time capacity over the last six months. Infection control matters, including surveillance results, are reported monthly to the general manager and information is presented at the six weekly quality forum. In addition, if the areas of discussion are pertaining to the registered nurses the information is also tabled at their meetings. The IPC committee includes the clinical quality manager, registered nurse and two enrolled nurses. There is a plan outlined to involve additional staff representing other areas of the service.</p> <p>Staff have guidance in policy on staying away from work when unwell. Clients/residents and visitors are guided to do the same by signage in the facility. Hand gel and signage is present throughout the facility alongside hand washing facilities. Staff are offered influenza vaccinations. There is evidence in client/residents' files and meeting minutes to demonstrate that staff provided education to clients and</p>

		their families on a one on one basis where issues of infection control are noted.
<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 IPC coordinator has appropriate skills, knowledge and qualifications for the role, and has been in this role for a number of years. The coordinator has undertaken study and course work in infection prevention and control and continues to attend local relevant study days at the district health board. The second registered nurse has attended the infection control course at the district health board. Training records were sighted. Additional support and information are accessed from the infection control team at the DHB, the community laboratory and the co-located GP practice. There is an annual review of the infection control programme by the infection control team with district health board input as required. The coordinator has access to clients' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection.</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 available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The infection prevention and control policies are tailored to the requirements at Pohlen Hospital. They reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies were current and included appropriate referencing. Staff were aware of standard precautions and were able to describe the situation and use of personal protective equipment and hand washing. Care delivery, cleaning, laundry and kitchen staff were observed following appropriate infection control and hygiene practices.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and through ongoing sessions at staff meetings. Additionally, staff are provided knowledge updates dependant on the analysis of surveillance data. An example sighted was the delivery of education on need for hydrating patients due to an increase in urinary tract infections. Clients/Residents in and family members are similarly educated by the team of registered nurses, both of whom are suitably qualified for their roles. The content of regular training sessions is documented</p>

		<p>and a record of attendance is maintained for all staff.</p> <p>There has been no ;infection outbreak since the last audit.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, skin, eye, gastro-intestinal, the upper and lower respiratory tract. The IPC team record all infections and these are documented in a spreadsheet. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. This system over the last six months has been further developed to improve the accuracy of data. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to the general manager and at the quality forum. Data, analysis and recommendations from October 2018 to January 2019 were reviewed along with meeting minutes. Staff interviewed confirmed surveillance information is shared and education is provided where a change or improvement in practice is required.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management of the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and the role and responsibilities. The clinical quality manager has been the restraint coordinator for over ten years and has just orientated a registered nurse to this role.</p> <p>On the day of the audit two residents were using a restraint. There were no residents using an enabler. Restraints are used as a last resort or when all other alternatives have been explored. This was evident on review of the restraint approval group minutes and records reviewed of those residents who have approved restraints and from interviews with the clinical manager. The newly appointed restraint coordinator was not available for interview during the audit.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types</p>	FA	<p>The restraint approval group is made up of the clinical quality manager, the registered nurse restraint coordinator, a health care assistant and the general practitioner. The group are responsible for the approval of the use of restraints and restraint processes as defined in policy. It was evident from the review of meeting minutes, review of residents' records and interview with the clinical manager that</p>

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.		there are lines of accountability and that all restraints have been approved and the overall use of restraints is being monitored and analysed. Graphs are completed monthly and results presented at the quality meeting. The care plans reviewed included documented restraint use and any risks associated, if applicable.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	Assessments for the use of restraint are documented on an assessment form that includes all requirements of the standard. The initial assessment is undertaken by a registered nurse. Input of the family/whanau is sought whenever possible. The clinical quality manager described the documented process. The GP signs off the final decision on the form provided. The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. The desired outcome was to ensure the resident's safety and security. Completed assessments were sighted in the records of residents who are using a restraint and all were signed appropriately.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	Restraint monitoring forms are used to record each episode of restraint use. When restraints are in use, hourly monitoring occurs to ensure the residents' needs are being met. The monitoring form is kept in the resident's record and is used by the restraint coordinator for monitoring usage and assessing conformity to the policy. The two restraints used are bedrails. It was seen that all processes ensure dignity and privacy is being maintained and respected. A restraint register is maintained, updated every month and reviewed at each restraint approval group meeting. Restraint will be discussed at the newly formed health and safety committee meetings. Staff have received training in the organisation's policy and procedures and in the safe application of restraint, as well as positively supporting people with challenging behaviours. Staff interviewed understood that the use of restraints is to be minimised and how to maintain safe use.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	Review of residents' records evidenced the individual use of restraints is reviewed and evaluated monthly by the restraint group and six monthly as part of the interRAI re-assessments, with input from family if possible, and documented evaluations by the GP. The evaluation meets the requirements of the standard. Policy and procedures were followed by staff and documentation was completed as required.

<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>The restraint committee review all restraint use monthly which includes all the requirements of the standard. Minutes of the group meeting confirmed analysis and evaluation of the amount of and type of restraint use in the facility, whether all alternatives to restraint have been considered, the effectiveness of the restraint in use and appropriateness of restraints. Restraint use is reported to the quality meetings and is an item on the meeting agenda sighted. Any changes to policy, guidelines, education and processes are implemented if indicated.</p>
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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)
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	PA Low	<p>The quality system has a number of forums where staff and/or clients/residents gather to confirm progress, raise concerns, discuss issues and develop solutions. The meeting minutes, staff and feedback confirmed issues are addressed. The volume of effort and work undertaken by management was evident from discussions, the incident register and meeting minutes. Where information is entered into an incident report, the process of follow up and/or close out is documented. However, there remains an inconsistency with the documentation of the corrective action process taken for all other issues raised. It is difficult to systematically track when the issue was raised, who is responsible, what actions have been taken, communications and the follow up or close out of the issue raised. For example, staff and management discussed a recent concern with a client's family member toward staff. The matter is being managed as required through communication with staff, the police, client and reporting to the board, however the documentation of the process or handling of the matter was not clearly presented. The management team confirmed that whilst all issues are addressed as they occur,</p>	<p>Issues and corrective action plans are discussed at all meetings and forums. However, the documentation of the process is inconsistent and does not routinely provide the details of the corrective action, follow up process and closure of identified issue.</p>	<p>Ensure there is a consistent process to document corrective action planning, actions taken and the follow up or close out of corrective actions.</p>

		where relevant, these are not transferred into complete documentation of the corrective action process or always documented in clients'/residents' files.		180 days
<p>Criterion 1.2.7.2</p> <p>Professional qualifications are validated, including evidence of registration and scope of practice for service providers.</p>	PA Low	There is a documented schedule that lists staff and their requirements for annual appraisals. Approximately 50% of the formalised appraisals have not been completed as required. Some of these are overdue by more than a year. With reference to the staff performance appraisal and orientation pack schedule, of the 54 staff listed as requiring appraisals, 28 of these are overdue their scheduled dates. Eleven of these are casual staff and three of the eleven are overdue.	Whilst there is a schedule to manage performance appraisals of staff, appraisals are not being completed as required.	<p>Ensure performance appraisals are completed in a timely manner.</p> <p>180 days</p>
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and</p>	PA Low	The medication management system is implemented to manage the safe and appropriate review, storage, disposal and medicine reconciliation in order to comply with legislation, protocols and guidelines. A signature verification list was available in all medication folders reviewed. Photo identification was in place. It was however observed that some records randomly selected to review had been completed by the nursing staff in readiness for the GP to sign on the next visit which does not meet the requirements. The provider was informed on the day and they provided an assurance that the matter would be addressed immediately on speaking with the staff member involved.	In total fourteen (14) medication records were reviewed across all services. Three of seven long term care residents' medication records evidenced transcribing had taken place. When new medication charts are needing to be rewritten nurses are transcribing the information and asking the general practitioners to sign this at their next	<p>Ensure that medical staff prescribe on the medication charts when a new medication record is required.</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, these 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 1.1.10.7 Advance directives that are made available to service providers are acted on where valid.	CI	The organisation has developed and implemented a project to introduce advance care planning (ACP) to staff, patients/residents/family/whanau and people in the community. The clinical quality manager (CQM) has attended relevant education at a leadership course to implement this programme successfully gaining level 2 and level 3 ACP training requirements. Also, the CQM has entry training with Hauraki PHO. Change models have been introduced at Pohlen on the current resuscitation plans to include, on the reverse of the form, provision for ACP discussions to be recorded. In-service education has been provided to staff and a display on the topic of ACP is on the wall in the staff room. I-service is planned six monthly in view of any new staff employed and is provided on an ongoing basis. The clinical quality manager interviewed	The achievement of implementing advance care planning has been well received by the registered nurses and medical practitioners. The general manager and the clinical quality manager have also presented in the community with groups of up to 80 - 250 people present and this was well received, and the ACP booklets were distributed. Feedback was very positive and appreciated by the group concerned and emails supporting this were reviewed. Other community groups have requested management to speak about this topic. A plan is in place for all staff to have completed ACP E-learning level 1 by the end of 2109. The outcome and benefit gained has been increased. Evidence in patients' records that registered nurses are having ACP discussions with the residents on admission and during their time in Pohlen. Family/whanau have shared from post death debriefs that there are benefits for both staff and the patients when they have an advance care plan. Staff interviewed stated they can better provide resident centred care

		speaks with the registered nurses to ensure they are confident in having the required discussions regarding resuscitation plans and end-of-life care wishes. The advance care planning booklets are available for all residents/patients.	knowing what the resident's individual wishes are.
<p>Criterion 1.1.4.3</p> <p>The organisation plans to ensure Māori receive services commensurate with their needs.</p>	CI	<p>After much planning over the past four years, the service has an end of life wing. The building was opened officially in March 2016. Staff have all received appropriate education on palliative care topics and this is ongoing. Education had a focus around Maori culture and how to manage Maori residents who access this service. Waikato hospice has been involved with Palliative care fundamentals education which included self-care. An ongoing wall display was sighted in the staff room at the onsite audit. This course has been repeated due to the success with staff and positive feedback. There has been an increase in Maori patients accessing this service requiring symptom management who have a terminal diagnosis. Maori admissions have been maintained at about 25 to 34 per year since 2016. In 2018 Maori bed-nights have peaked from 70 in 2016 to 138 in 2018. Eight end of life admissions were recorded in 2018 and there were no admissions in 2016. Spirituality needs (Te Wairua) are able to be met in various ways. Staff are allocated time to sit and have discussions with residents.</p>	<p>The achievement of implementing support and services to meet the needs of residents who identify as Maori is rated beyond the expected full attainment. The service's approach and philosophy in provision of culturally appropriate care for Maori is gaining positive results. The importance of whanau in the patient's care is paramount. The rooms are spacious to accommodate the extended whanau. With this culturally appropriate model of end-of-life care and philosophy implemented Maori patients feel safe and have increased connection with their spirituality, whanau and staff. Positive outcomes have been measured through staff, patient/resident and family/whanau satisfaction surveys.</p>
<p>Criterion 1.3.13.1</p> <p>Food, fluid, and nutritional needs of</p>	CI	<p>Review of data occurred over a six-month period from June 2017 to December 2017. Trends evidenced from the feedback received showed dissatisfaction with the meals served, the time of day the meals were served and the</p>	<p>A continuous improvement rating is made for achievement beyond the expected full attainment for the changes made to the food services, and in particular for the maternity service clients. Feedback from women had been very negative in relation to the food provided in the maternity unit. The main meal was served at</p>

<p>consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.</p>		<p>inappropriateness of the meals provided for women recovering from a birth and/or lactating women. In addition to this the short and long-term patients in the hospital were not pleased with the meals provided. The general manager discussed this with the board of Pohlen Hospital and sought agreement of the Board to make appropriate changes and to follow through with additional feedback. Discussions with the clinical quality manager, midwives, kitchen manager and midwifery assistants and staff were held with management. The contracted dietitian was also involved for reviewing the new menu plans for both the maternity and hospital services. The general manager had also investigated sourcing meals externally for the facility for the evening meal for the maternity service.</p>	<p>lunchtime and it was a long time until breakfast especially if women were lactating. The menu has now been changed after consultation with respective staff and networking with another maternity provider in the region. The outcome of which is that Pohlen Hospital kitchen staff provides breakfast and a choice of sandwiches and snacks. A trial is underway for a local restaurant to provide the evening meal and dessert. Menu plans are available daily with choices and this is delivered to the unit. The other residents receive their planned main meal at lunchtime and are asked their preferences in the afternoon for their evening meal from the menu provided also offering alternatives as required. This trial has evidenced decrease in meal repetition, decrease of salty meals on the menu, and meal texture is assessed daily. The main meal served in the evening in the maternity unit from the external provider has more choices of vegetables. Special dietary needs are catered for. Feedback overall has been very positive and in particular from the women accessing the maternity service.</p>
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End of the report.