Pohlen Hospital Trust Board - Pohlen Hospital Trust Board

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	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: 10 May 2021 End date: 10 May 2021

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 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
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Pohlen Hospital Trust Board (Pohlen Hospital) provides rest home and hospital level care (medical and geriatric) and hospital services (surgical and maternity) for up to 33 residents. The service is operated by a charitable trust board and managed by a general manager and a clinical quality manager. Residents and families interviewed from all areas of service delivery are very satisfied with the care and management provided.

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

The audit has resulted in three areas for improvement. Two in relation to human resources management, training and staff appraisals and one in relation to interRAI assessment timeframes not being met. There were three areas of improvement raised at the last audit, two of these have been addressed and the one relating to staff appraisals remains open.

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.

Systems support clear and timely communication with all consumers. Interpreter services are available and accessed by staff when required. Policies are in place to support effective communication and open disclosure.

The complaints management system meets the requirements of the Code off Health and Disability Services Consumers' Rights (the Code) and was known by staff, consumers and their families. Issues and concerns raised are discussed and addressed by the team at Pohlen Hospital.

Organisational management

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

Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body is regular and effective.

There is an established quality and risk management system with a focus on continuous improvement. Data is collected, analysed and shared with staff and consumers. There is a cycle of improvement and a focus on better outcomes for residents and patients at Pohlen Hospital. Staff are involved and feedback is sought from all users of the services and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and 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 regular observation of practice and performance reviews. Staffing levels and skill mix meet the changing needs of residents.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

The multidisciplinary team are involved with the assessment and admission process on admission and for ongoing service delivery. Care plans are individualised and based on a comprehensive range of information. An electronic record system has been introduced since the previous audit and was being implemented for the long term residents' care and management.

The lead maternity care midwives are responsible for the women under their care and assess women daily when in the maternity unit. Maternity healthcare assistants provide care and support to women with breastfeeding and baby cares and are overseen by a midwife. Parenting education is provided and encouraged.

There is an activity programme that has strong links to the community. Individual and group activities are provided with an interesting and motivating programme in place.

Medicines are managed and administered by staff who are competent to do so. An electronic medication system has been introduced since the previous audit.

The food service meets the nutritional needs of the residents with all special needs being catered for. Residents/family verified satisfaction with the meals. The food service operates with a current food safety plan in place.

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.

There have been no changes to the buildings since the last audit. Pohlen Hospital has a current building status systems report. Planned and reactive maintenance of equipment and the environment is occurring routinely with a number of initiatives in progress and plans being developed to improve the safety and efficiency of the environment for all users of the service.

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.

Pohlen Hospital has implemented policies and procedures that support the minimisation of restraint. One resident was using a restraint and one was using an enabler at the time of the audit. Use of enablers is voluntary for the safety of residents in response

to individual requests. An assessment, approval and monitoring process with regular review occurs. Staff interviewed have a good understanding of the restraint and enabler processes.

Infection prevention and control

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

A planned infection surveillance programme is undertaken, and results reported through all levels of the organisation. Follow-up investigation is conducted, and action 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	14	0	0	2	0	0
Criteria	0	38	0	1	2	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 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	Information on how to make a complaint is made available to residents, patients, family and staff. The policy outlines the requirement of Right 10 of the Code and a clear system is in place to manage and document complaints. The general manager (GM) and clinical quality manager (CQM) have oversight of the complaints process and confirm they continue to resolve issues as they are raised by residents/patients and staff, and have not received any direct complaints since the last audit. Staff meeting minutes and clinical records confirmed there is a process to address issues/concerns as they are raised. The GM outlined a current case being managed where issues are raised on a routine basis. Related documents sighted verified the regular communication with the resident, mental health support worker, consumer advocate and requests to the district heath board for a transfer. Rules of communication have been established by the relevant parties to manage this on and ongoing basis. Pohlen Hospital was requested by the Health and Disability Commissioner's Office to provide information relating to a complaint originating at the adjacent general practice but raised by a family member of one of their residents. This complaint is now closed. A complaints register is in place and in due course this system will be transferred to an electronic quality management system.

Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Residents and family members are kept informed in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was verified by staff discussion, resident interviews and from records reviewed. The principles of open disclosure are understood and supported by policy. A system to provide for and access interpreter services is in place. Staff spoken with knew how to access these services.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	The strategic plan is developed every three years and operational business plans are reviewed annually. The purpose, values, scope, direction and goals of the organisation are clearly documented. The board has seven members, two of whom identify as Maori. They meet monthly and a sample of the GM'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 GM interviewed discussed current issues and new strategies refocusing on Maori Health and access, professional development opportunities for the board members and a clinical governance review for maternity services. The service is managed by a general manager who holds relevant qualifications and has been in the role for more than four years. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The board along with the GM are in the process of outlining key performance indicators for the job to better support role development. The general manager understands regulatory and reporting requirements, is knowledgeable about the sector and the model of service delivery at Pohlen Hospital. Currency of information is managed through attendance at 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. The service holds contracts with the DHB for residential respite, primary care in-patient services (General Practitioner clients), palliative care, transitional care and maternity care. Twenty-seven people were receiving care on the first morning of audit. Of these, 22 were receiving hospital level care, one palliative care, one Post-Acute Convalescent Care (PACC) and there were two GP clients. There was one woman in the maternity suite on the day of audit being cared for by a private lead maternity carer midwife.

Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	The organisation has an established quality and risk management system with components that include the reporting and management of incidents and concerns/complaints, planned audit activities, identification of hazards and risk, staff and resident/patient feedback, health and safety components, monitoring of infections and outcomes. The CQM and GM understand and promote the principles of continuous quality improvement. Various committee meetings are held overseeing all areas of practice, staff and service users. The information and outcomes from these meetings, various quality activities and feedback are discussed at a monthly quality and risk meeting – the Quality Forum. The GM and CQM have needed to risk assess and manage the frequency of planned quality activities over the last 12 months in view of the additional workload brought about by the Covid-19 pandemic. The Quality Forum meeting is managed with rigour as reflected in the meeting minutes which confirmed discussion of information, audit outcomes, data analysis, reporting and the development and close out of corrective actions. This addresses a previous corrective action. The CQM and GM are both registered nurses and work alongside staff to identify and better understand practice issues. Pohlen Hospital has purchased an electronic quality management system which will be rolled out over the next 12 months with staff training provided on its use. This will further enhance an established quality and risk management system. 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 is managed efficiently and provides a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. The GM interviewed described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The risk register is reviewed at the board meeting and minutes verified discussions on matters of risk including the pandemic, staffing and succession planning, for example. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements. The workplace has been very busy over the last 12 months as reflected in staff and management comments and although a number of wellness activities could not go ahead there remains a continued focus on consumer safety and staff health.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the	FA	Pohlen Hospital is transitioning from a paper based incident and adverse management system to an electronic system. Staff have received some training on the new system and this continues. All adverse and near miss events are entered into the system. A sample of incident reporting forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to staff, patients/residents and the board. There is evidence of discussion and corrective actions being taken with improved outcomes to practice. For example, initiatives to reduce the number of skin tears included training on safer handling, a reduction in the number of falls included training of staff and residents/patients, the introduction of afternoon ‘naps’ and the purchase of new low beds, for example.

service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.		The management team described essential notification reporting requirements. There have been no essential notifications required since the last audit.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA Moderate	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 four records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained. Staff orientation includes all necessary components relevant to the role. The staff records reviewed showed documentation of completed orientation and catch-up reviews. 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 registration requirements. There has been a steady turnover of staff over this last year with some difficulties in retaining staff due to pay parity issues. Management report that this has stretched the functionality of the team and the human resources management systems. Where previously there was a clear system of recording staff competencies, ongoing education and educational needs, this now is an area for improvement. Staff continue to report having a number of opportunities to train and learn new skills. Whilst there is a schedule of annual performance appraisals the completion of these is an area needing improvement.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	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 residents/service users. There are two RNs on duty morning and afternoon reflective of the increased acuity of patient/residents receiving care. They work with the support of healthcare assistants whose numbers are also 'flexed' depending on the acuity and care needs of the residents/patients. An afterhours on call roster is in place, managed by the GM and CQM. There are four RNs who support this roster currently, these include the GM and CQM. The co-located GP practice continues their support of Pohlen Hospital. Observations and review of two four-week roster cycles confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. Pohlen Hospital uses one agency for staff cover. All registered nurses

		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. Midwives are on call 24 hours/seven days a week and are supported by a maternity aide. The RN from the ward supports the maternity area when the LMC's are not onsite. The service has dedicated cleaning, laundry and kitchen staff seven days a week. One diversional therapist covers the weeks activities.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	The medication policy is current and identifies all aspects of medication management. A safe system for medicine management was observed on the day of the audit. As a result of areas requiring improvement in relation to medicine management in the previous audit an electronic medicine system has been introduced and the areas of concern have been fully addressed. Medications are supplied to the facility in a pre-packaged format from the preferred contracted pharmacy. An RN checks the medications against the prescription. All medications sighted were current. Clinical pharmacist input is provided as required. The controlled drugs are stored appropriately and checked by one registered nurse and one other registered nurse or a HCA for all patients. The pharmacist checks all controlled drugs weekly. Stock checks occur six monthly. There were no controlled drugs stored in the maternity service. Midwives prescribed medications within their scope of practice. Minimal medicines were stored in the maternity service. Senior health care assistants are competent second checkers. Two registered nurses interviewed stated they are fully trained in all aspects of medicine management processes. The pro-rata medicines (PRN) administered are monitored for effectiveness. The temperature records of the medicine fridges in the ward, maternity unit and the medication room in the ward were maintained within the recommended range. The three-monthly reviews for the long term residents were current and the GP interviewed was experienced with using the electronic system implemented. The short-term residents' medication records are still in hard copy format. A specimen signature list and registration numbers were maintained. No residents were self-administering medicines at the time of the audit. There is an implemented process for comprehensive analysis of any medication errors.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's	FA	The food service is provided on site by two cooks and kitchen aides. The cook interviewed had worked in this role for two years and was very experienced. The menu follows seasonal patterns and was last reviewed within the last two years. The food service operates with an approved food safety plan and registration issued by the Waikato Council which is due to expire next 13 February 2022. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cook and kitchen aides have completed food safety

individual food, fluids and nutritional needs are met where this service is a component of service delivery.		training and qualifications are recorded in the personal records reviewed. 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 and residents were given adequate time to eat their meal and those requiring assistance had this provided. The cook interviewed stated the women in the maternity unit had choices and availability of additional food was provided twenty-four hours a day. Partners can order a meal as well. Feedback was provided by a woman who had received postnatal care who stated the meals were homely and nourishing. A nutritional assessment was undertaken for each resident on admission to the facility and a dietary profile was developed. A copy was retained on the personal records of residents and the cook and kitchen staff received a copy. The personal preferences, modified texture and portion sizes are known to kitchen staff and any special diets are catered for and accommodated in the daily meal plan.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Residents' records were reviewed. Documentation observations and interviews verified the care provided to residents/patients was consistent with their individual needs, goals and the plan of care. The resident electronic record system for long term care has been introduced since the last audit. Staff have been trained appropriately and records are well maintained. The attention to meeting a diverse range of resident's individualised needs was evident as many residents have multiple diagnosis and complex needs. The GP practice is centralised on site at Pohlen Hospital. The GP interviewed verified that medical input is sought in a timely manner and that medical orders were followed and care is managed well with the clinical manager's input. The residents have the choice of staying with their own GP who supported them when they lived in the community. The care staff confirmed at interview that care was provided as per the care plan. A range of resources and equipment is available suited to all levels of care provided and in accordance with the resident's/patient's individual needs. Monitoring of those residents who present with challenging behaviour occurs as needed. For the primary maternity service, the maternity aide interviewed confirmed the care is provided as per the care plans of the mother and baby. There are seven maternity aides trained to cover the service. The women interviewed stated that they are involved in their own care planning and independence is encouraged. The baby friendly hospital initiative (BFHI) is by self-assessment presently, due to the Covid-19 pandemic the statistics were not maintained accurately. Full support is provided by staff for woman to breastfeed their babies and the ten steps to successful breastfeeding is displayed in the unit.
Standard 1.3.7: Planned Activities Where specified as	FA	The activities programme is provided by an activities co-ordinator who has been one year in the role. The person previously trained as a healthcare assistant (HCA). The activities co-ordinator is supported by volunteers. A designated volunteer van driver has a current first aid certificate. Networking with other aged care facilities is encouraged and with the community at large. Van outings occur twice a week which the residents interviewed

part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.		enjoyed. The van driver also takes residents to appointments if required. A social history and assessment is undertaken on admission to ascertain resident's interests, needs, abilities and social requirements. The programme reviewed is varied and is meaningful to the resident group. The activities co-ordinator is transitioning the activities records onto the electronic system. The co-ordinator is involved with input into the interRAI assessment and care planning processes. Activities reflected residents' goals, ordinary patterns of life and include normal community activities. Individual, group and one on one activities are provided. Residents and families/whanau are involved and are welcome to participate or be involved at the resident meetings. Hospital level residents also enjoy the group or the one-on-one activities provided. Other residents admitted for short term care are welcome to participate in the activities programme. The attendance records are maintained and the progress records are updated regularly. The newly implemented electronic system was explained and this will monitor time people attend a particular event. The family/whanau interviewed and residents were pleased with the activities provided and family members were present on the day of the audit participating with their relatives. The activities lounge is large in size and can be divided off with several activities in progress at any one time. There is a television in the main lounge of the maternity unit for woman and their families to access. Also, DVD material is available from an education perspective with interesting topics for new parents. Pamphlets and resources are readily available throughout the unit for parent to access. The maternity assistants can demonstrate baby bathing, safe sleeping and techniques for promoting successful breastfeeding. The woman interviewed was pleased to have the support at all stages of service delivery and a refresher of newborn cares for her baby and for breastfeeding.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	PA Moderate	Residents' care is evaluated on each shift and reported in the progress notes. If any change is noted it is reported to the RN. Formal care plan reviews occur six monthly in conjunction with the six monthly interRAI reassessments, or as the residents' needs change. Currently a significant number of the interRAI assessments are overdue (50%) and therefore the care planning is not formally up to date. However, any changes were recorded in the progress records reviewed and this was reflected on some of the care plans reviewed. Examples of short-term care plans being instigated and consistently reviewed and progress evaluated as clinically indicated was noted for infections or wound care. Residents and family members interviewed stated that they were involved in evaluation of progress if changes occurred and at the multidisciplinary (MDT) meetings. The resuscitation status is reviewed along with the six-monthly MDT meetings. The resident records of those admitted in the GP allocated beds were reviewed and were clearly documented with the assessment and progress records being up to date.

		The clinical records reviewed in maternity confirmed evaluations occur and are documented through all stages of service delivery. This included the mother and the baby. Ongoing evaluations were recorded with each point of contact with the mother and the baby on the relevant progress records. Discussions were held between the maternity assistants and the midwives concerned. If there are any changes to the mother and the baby, the maternity assistants contacts the lead maternity midwife directly or the contracted midwifery coordinator for this unit.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	A current building systems status report is in place (expiry date 1 September 2021). There have been no changes made to the structure of the building since the previous audit, however plans are being developed to extend and reorganise the layout of some areas within the original building. Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The facility management have embarked on a plan to purchase new sensor mattresses and low beds to support the work being done by staff to improve the safety of residents. Five new low beds and sensor mattresses are already in use, with one of these purchases being a bariatric sized bed and mattress. A new maternity bed has also been purchased. The testing and tagging of electrical equipment and calibration of bio medical equipment is current. Staff and residents have no concerns with regards to the facility or environment and confirm the facility is maintained well also observed on the day of audit. The environment was hazard free, residents/patients were safe and independence is promoted. External areas are safely maintained and are appropriate to the resident/patient groups and setting. A new garden area has been created for the residents/patients to enjoy the outdoors in a managed environment.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	The infection control surveillance programme is managed by the CQM. Surveillance for infection is appropriate to that recommended for long term care facilities and primary maternity care settings which includes infections of the urinary tract, soft tissue, skin, eye, gastro-intestinal, the upper and lower respiratory tract, operation site infections and pyrexia of unknown origin. All staff are involved in reporting an infection or treatment being provided for an infection. The CQM reviews all entries, investigates and follows up on results. New infections and any required management plan are discussed at handover, to ensure early intervention occurs. This surveillance data is collated monthly and analysed to identify any trends, possible causative factors and required actions. There have been no trends requiring specific interventions since the last audit. Data is graphed and presented at the infection control committee meetings and staff meetings. Meeting minutes verify the discussion on data and individual cases of infection. Staff interviewed confirmed surveillance information is shared and education is provided where a change or improvement in practice is required.

Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	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. On the day of audit, one resident was using a restraint and one resident was using an enabler. Enablers were the least restrictive and are used voluntarily at their request. Restraint is used as a last resort when all other alternatives have been explored. The individual resident's records were reviewed, and evidenced restraint approval had been sought and appropriate monitoring occurred. This provides for a robust process which ensures the ongoing safety and wellbeing of the resident.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.7.2 Professional qualifications are validated, including evidence of registration and scope of practice for service providers.	PA Moderate	The staff appraisals management system continues to lag with inadequate progress since the last audit. A register of completed performance reviews identified more than 50% of staff are over their due date for review. Staff turnover and a busy 12 months are some contributing factors. Casual staff are included in this percentage and new staff were not.	Annual performance appraisals of staff are overdue by more than 50%.	Ensure a system is put in place to manage the delivery of annual performance appraisals. 90 days
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing	PA Low	An annual training plan was reviewed along with a schedule for the training to occur. A number of documents and training register records were provided. The staff training register reflects completed and current competencies for first aid for the RNs; however, reflects overdue training in other areas. The CQM and staff confirmed they have completed some of	There is more than one location where staff training is recorded in the system. Collated	Ensure training records of staff are held in a systematic manner to

education for service providers to provide safe and effective services to consumers.		this training. However due to the busy last 12 months the documentation of training has not been consistently recorded or recorded in one place. The lack of collated information has made it difficult to identify overdue training or gaps, if any, in the training needs of staff.	data is not complete and does not provide a current training status for individual staff.	enable the assessment of the current status of staff training at a glance. 180 days
Criterion 1.3.8.2 Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.	PA Moderate	The residents' individual interRAI reassessments are to be reviewed six monthly and the care plan updated from the outcomes or triggers produced by the assessment process. There are two RNs who are interRAI competent. This has not been occurring mainly due to the transitioning of the resident records to the electronic system now in place. Over 50% of the interRAI and care plans are currently not up to date. However, these are required for all long-term residents and other residents as needed due to the nature of the services provided at Pohlen Hospital. The clinical quality manager is fully aware and has a plan developed to address this area of improvement required.	Ten of twenty long term care residents have not had there interRAI reassessments completed in the required timeframe since July 2020 and the majority of the care plans have not been updated.	Ensure the interRAI re-assessments are completed to ensure the care plans reflect the appropriate care required for each individual resident concerned. 90 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.