

Frances Hodgkins Retirement Village Limited - Frances Hodgkins Retirement Village

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 Health and Disability Auditing New Zealand 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: Frances Hodgkins Retirement Village Limited

Premises audited: Frances Hodgkins Retirement Village

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 18 April 2016 End date: 19 April 2016

Proposed changes to current services (if any): This audit also included verifying the suitability of a further three rooms in the serviced apartments, which takes the total of serviced apartments to 32 for rest home level care.

Total beds occupied across all premises included in the audit on the first day of the audit: 55

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

Frances Hodgkins is part of the Ryman Group of retirement villages and aged care facilities. They provide rest home level care for up to 80 residents in a 51 bed rest home care centre and in 29 serviced apartments. On the days of the audit, there were 55 residents.

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the District Health Board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management, staff and a general practitioner.

This audit also included verifying the suitability of a further three rooms in the serviced apartments, which takes the total of serviced apartments to 32 for rest home level care.

The village manager is appropriately qualified and experienced, and is supported by a clinical manager and the Ryman regional manager. There are quality systems and processes being implemented. The residents and relatives interviewed spoke positively about the care and support provided.

The service is commended for achieving continuous improvements around good practice, falls prevention programme, induction programme and infection surveillance.

Consumer rights

<p>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.</p>		<p>All standards applicable to this service fully attained with some standards exceeded.</p>
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Policies and procedures that adhere with the requirements of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (e.g., the Code) are in place. The welcome/information pack includes information about the Code. Residents and families are informed regarding the Code and staff receive on-going training about the Code.

The personal privacy and values of residents are respected. There is an established Maori Health plan in place. Individual care plans reference the cultural needs of residents. Discussions with residents and relatives confirm that residents and where appropriate their families are involved in care decisions. Regular contact is maintained with families including if a resident is involved in an incident or has a change in their current health. Families and friends are able to visit residents at times that meet their needs.

There is an established system for the management of complaints.

Organisational management

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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Services are planned, coordinated, and are appropriate to the needs of the residents. A village manager and clinical manager are responsible for the day-to-day operations. Goals are documented for the service with evidence of regular reviews. A


comprehensive quality and risk management programme is in place. Corrective actions are implemented and evaluated where opportunities for improvements are identified. The risk management programme includes managing adverse events and health and safety processes.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. A comprehensive orientation programme is in place for new staff. On-going education and training is in place, which includes in-service education and competency assessments.

Registered nursing cover is provided seven days a week and on call 24/7. Residents and families report that staffing levels are adequate to meet the needs of the residents.

The integrated residents' files are appropriate to the service type.

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.		Standards applicable to this service fully attained.
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Care plans and evaluations reviewed were completed by the registered nurses within the required timeframe. Monitoring forms were being utilised. Care plans demonstrate service integration. Resident and family interviewed confirmed they were involved in the care plan process and review. Care plans were updated for changes in health status.

The activity team provide an activities programme in each unit that meets the abilities and recreational needs of the residents. The programme reviewed was varied and involved the families and community.

There are policies and processes that describe medication management that align with accepted guidelines. Staff responsible for medication administration have completed annual competencies and education. There are three monthly GP medication reviews. Medications are appropriately stored, managed, administered and documented.

Meals are prepared on site in a clean well managed kitchen. The menu is designed by a dietitian at an organisational level. Food, fridge and freezer temperatures are recorded. Individual and special dietary needs are catered for.

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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The building has a current warrant of fitness. There is a preventative and planned maintenance schedule in place. Chemicals were stored safely throughout the facility. All bedrooms are single occupancy with toilet and hand basins. Communal shower facilities are provided in the rest home area. All serviced apartments have a kitchenette and bathroom. There was sufficient space to allow the movement of residents around the facility and in the service apartments. The hallways and communal areas were spacious and accessible. The outdoor areas were safe and easily accessible. Housekeeping staff maintain a clean and tidy environment. All laundry services are managed on-site.

There are appropriate systems and equipment for emergency management. The call bell system is linked between the rest home and the serviced apartments.

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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Staff receive training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. There were no residents with restraint or enablers at the time of audit. Staff have received education and training in restraint minimisation and managing challenging behaviours.

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.

All standards applicable to this service fully attained with some standards exceeded.

The infection prevention and control programme includes policies and procedures to guide staff. Infection surveillance is completed and a monthly infection control report is completed and forwarded to head office for analysis and benchmarking. A weekly meeting on site reviews all infections to ensure appropriate care is in place. A six monthly comparative summary is completed.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	2	43	0	0	0	0	0
Criteria	4	89	0	0	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
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Ryman policies and procedures are being implemented that align with the requirements of the Code of Health and Disability Services Consumer Rights (the Code). Families and residents are provided with information on admission that includes information on the Code. Staff receive training about resident rights (and the Code) at orientation and as part of the annual in-service calendar. Interviews with six care assistants and the clinical manager demonstrated an understanding of the Code. Ten residents interviewed and three relatives confirmed that staff respect privacy, and support residents in making choice where able.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Informed consent processes are discussed with residents and families on admission. Written consents are signed by the resident or their EPOA. Advanced directives are signed for separately. There is evidence of discussion with family when the GP completed a clinically indicated not for resuscitation order. Care assistants and registered nurses interviewed confirmed verbal consent is obtained when delivering care. Discussion with family members identified that the service actively involves them in decisions that affect their relative's</p>

		<p>lives.</p> <p>All eight resident files sampled, including one respite file, had signed admission agreements and consents.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>Residents are provided with a copy of the Code on entry to the service. Residents interviewed confirmed they are aware of their right to access independent advocacy services. Discussions with relatives confirmed the service provided opportunities for the family/EPOA to be involved in decisions. The resident files include information on residents' family/whānau and chosen social networks.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. The activities programmes included opportunities to attend events outside of the facility including activities of daily living, for example, shopping. Residents are supported and encouraged to remain involved in the community and external groups. Relatives and friends are encouraged to be involved with the service and care.</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 service has a complaints policy that describes the management of the complaints process. Complaints forms are available. Information about complaints is provided on admission. Interviews with residents and family members confirmed their understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints.</p> <p>A complaints register includes written and verbal complaints, dates and actions taken. Complaints are being managed in a timely manner meeting time frames determined by the Health and Disability Commissioner (HDC). One complaint was lodged in 2015 and none in 2016 (year to date). There is evidence of complaints received being discussed in staff and management meetings. All complaints received have been documented as resolved. Complainants are provided with information on how to access advocacy services through the Health and Disability Commissioner if resolution is not to their satisfaction.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p>	FA	<p>There is an information pack given to prospective residents and families that includes information about the Code and the nationwide advocacy</p>

<p>Consumers are informed of their rights.</p>		<p>service. There is the opportunity to discuss aspects of the Code during the admission process. Residents and relatives interviewed confirmed that information had been provided to them around the Code. Large print posters of the Code and advocacy information are displayed through the facility. The village manager discusses the information pack with residents/relatives on admission. Families and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement.</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>	<p>FA</p>	<p>A tour of the premises confirmed there were areas that support personal privacy for residents. During the audit, staff were observed to be respectful of residents' privacy by knocking on doors prior to entering resident rooms. Staff could describe definitions around abuse and neglect that aligned with policy. Residents and relatives interviewed confirmed that staff treat residents with respect.</p> <p>The service has a philosophy that promotes quality of life and involved residents in decisions about their care. Resident preferences are identified during the admission and care planning process and this includes family involvement. Interviews with residents confirmed their values and beliefs were considered. There were instructions provided to residents on entry regarding responsibilities of personal belongings in their admission agreement.</p> <p>Interviews with care assistants described how choice is incorporated into resident care provision.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>Ryman has a Maori health plan that includes a description of how they achieve the requirements set out in the contract. There are supporting policies that provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. Family/whanau involvement is encouraged in assessment and care planning and visiting is encouraged. Links are established with disability and other community representative groups as requested by the resident/family. Maori residents have their cultural needs identified and recorded in the care plan.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p>	<p>FA</p>	<p>An initial care planning meeting is carried out where the resident and/or whanau as appropriate are invited to be involved. Individual beliefs or</p>

<p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>		<p>values are further discussed and incorporated into the care plan. Six monthly multi-disciplinary team meetings occur to assess if needs are being met. Family are invited to attend. Discussions with relatives confirmed that residents' values and beliefs are considered. Residents interviewed confirmed that staff take into account their cultural values.</p>
<p>Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Staff job descriptions include responsibilities. The full facility meetings occur monthly and include discussions on professional boundaries and concerns as they arise. Management provided guidelines and mentoring for specific situations. Interviews with staff confirmed an awareness of professional boundaries.</p>
<p>Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.</p>	CI	<p>All Ryman facilities have a master copy of policies, which have been developed in line with current accepted best practice and these are reviewed regularly or at least three yearly. The content of policy and procedures are sufficiently detailed to allow effective implementation by staff. A number of core clinical practices also have education packages for staff, which are based on their policies.</p> <p>A range of clinical indicator data are collected against each the service level, and reported through to Ryman Christchurch (formerly known as head office) for collating, monitoring and benchmarking between facilities. Indicators include resident incidents by type, resident infections by type, staff incidents or injuries by type, and resident and relative satisfaction. Feedback is provided to staff via the various meetings as determined by the Ryman programme (previously known as Ryman Accreditation Programme RAP). Quality improvement plans (QIP) are developed where results do not meet expectations. An electronic resident care system is used by all sites to report relevant data through to Ryman Christchurch (head office). The system of data analysis and trend reporting is designed to inform staff at facility level. Management at facility level are then able to implement changes to practice based on the evidence provided.</p>
<p>Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Open disclosure occurs between staff, residents and relatives. Staff are guided by the incident reporting policy, which outlines responsibility around open disclosure and communication practices. Staff are required to record family notification when entering an incident into the database. Incidents reviewed met this requirement. Family members</p>

		interviewed confirmed they are notified following a change of health status of their family member. There is an interpreter policy in place and contact details of interpreters were available.
<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>Frances Hodgkins is a Ryman healthcare retirement village, which provides rest home level care across a care centre and in serviced apartments. The care centre can accommodate up to 51 rest home residents with 49 residents on the day of audit. This included three respite residents. There are 32 serviced apartments adjoining the care centre. The apartments are part of an eight storey, retirement village complex adjacent to the rest home. Twenty-nine of these are currently certified for rest home level care. This audit assessed the three remaining serviced apartments for rest home level care. There were six rest home level residents in the serviced apartments. All residents are under the age related contract.</p> <p>There is a documented service philosophy set at Ryman Christchurch (head office) that guides quality improvement and risk management in the service. Specific values have been determined for the facility. Organisational objectives for 2016 are defined with evidence of monthly reviews and quarterly reporting to head office on progress towards meeting these objectives. Evidence in staff and management meeting minutes reflect discussions around the 2016 objectives.</p> <p>The village manager at Frances Hodgkins has been in the role for eight years and is a registered nurse. She is supported by a clinical manager (registered nurse) who oversees clinical care. The management team is supported by the wider Ryman management team that includes a regional manager. The village manager and clinical manager have maintained at least eight hours of professional development activities related to managing an aged care service.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>The clinical manager is responsible during the temporary absence of the village manager, with support from the regional manager and Ryman Christchurch team.</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>FA</p>	<p>Frances Hodgkins has a well-established quality and risk management system that is directed by Ryman Christchurch. Quality and risk performance is reported across the facility meetings and to the organisation's management team. Discussions with the management team, care assistants, one cook, one activities coordinator, one cleaner, one laundry person, and one maintenance staff member, and review of management and staff meeting minutes, demonstrate their involvement in quality and risk activities.</p> <p>Resident meetings are held two monthly and relative meetings are held six monthly. Minutes are maintained. Annual resident and relative surveys are completed. Quality improvement plans are completed with evidence that suggestions and concerns are addressed.</p> <p>The service has policies, procedures, and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are reviewed at a national level and are forwarded through to a service level in accordance with the monthly team. Ryman programme calendar. They are communicated to staff, as evidenced in staff meeting minutes. Updates to policies and procedures include procedures around the implementation of InterRAI.</p> <p>The quality monitoring programme is designed to monitor contractual and standards compliance, and the quality of service delivery in the facility and across the organisation. There are clear guidelines and templates for reporting. Service appropriate management systems, policies, and procedures are developed, implemented and regularly reviewed for the sector standards and contractual requirements.</p> <p>The facility has implemented processes to collect, analyse and evaluate data, which is utilised for service improvements. Results are communicated to staff across a variety of meetings and reflect actions being implemented and signed off when completed.</p> <p>Health and safety policies are implemented and monitored by the two monthly health and safety committee meetings that also include review of infection control and of incidents. A health and safety officer is appointed who has completed stage three health and safety training. Risk management, hazard control and emergency policies and</p>
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		<p>procedures are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. The data is tabled at staff and management meetings. Ryman has achieved tertiary level ACC Workplace Safety Management Practice. The hazard identification resolution plan is sent to head office, and identifies any key hazards that are identified. A review of this, the hazard register and the maintenance register indicates that there is resolution of issues identified.</p> <p>Falls prevention strategies are in place. The service has achieved a continuous improvement in relation to falls reduction.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Individual incident reports are completed electronically for each incident/accident with immediate action noted and any follow up action required.</p> <p>A review of a sample of incident/accident forms for March 2016 identifies that all are fully completed and include follow-up by a registered nurse. The village manager and clinical manager are involved in the adverse event process, with the regular management meetings and informal meetings. This provides the opportunity to review any incidents as they occur.</p> <p>The village manager is able to identify situations that would be reported to statutory authorities.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Eight staff files reviewed (the clinical manager, four care assistants, one activities coordinator, one cook and one housekeeper) included a signed contract, job description relevant to the role the staff member is in, induction, application form and reference checks. All files reviewed included annual performance appraisals with eight week reviews completed for newly appointed staff.</p> <p>A register of registered nurse practising certificates is maintained within</p>

		<p>the facility. Practicing certificates for other health practitioners are retained to provide evidence of registration.</p> <p>A comprehensive orientation/induction programme provides new staff with relevant information for safe work practice. It is tailored specifically to each position. The time allocated for orientation/induction training has been increased to five days. The service has achieved a continuous improvement around implementation of the induction programme.</p> <p>There is an implemented annual education plan. The annual training programme exceeds eight hours annually. There is an attendance register for each training session and an individual staff member record of training. Evaluations are completed for all training provided. Registered nurses are supported to maintain their professional competency. Two registered nurses have completed their InterRAI training, meeting contractual requirements. Staff training records are maintained. There are implemented competencies for registered nurses and care assistants related to specialised procedure or treatment including medication competencies and insulin competencies.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>A policy is in place for determining staffing levels and skills mix for safe service delivery. This defines staffing ratios to residents. Rosters implement the staffing rationale. There are a minimum of two care assistants on duty at any time in the rest home. The serviced apartment area is staffed during the morning and afternoon shift with rest home care assistants providing cover to the serviced apartments overnight. Every rest home resident in the serviced apartments is checked two hourly. Night staff wear pagers, which are linked to the call system in the serviced apartments.</p> <p>Staff were attending to call bells in a timely manner, as confirmed by all residents interviewed. Staff interviewed stated that the staffing levels are satisfactory and that the management team provide good support. Residents and family members interviewed report there are adequate staff numbers.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately</p>	<p>FA</p>	<p>The resident files were appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Information</p>

recorded, current, confidential, and accessible when required.		containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files were protected from unauthorised access. Entries are legible, dated and signed by the relevant care assistant or registered nurse including designation. Individual resident files demonstrate service integration.
<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>There are policies and procedures to safely guide service provision, and entry to services including a comprehensive admission policy.</p> <p>Information gathered on admission is retained in residents' records. Relatives interviewed stated they were well informed upon admission. The service has a well-developed information pack available for residents/families/whānau at entry.</p> <p>The admission agreement reviewed aligns with the service's contracts. Eight admission agreements viewed were signed. Exclusions from the service are included in the Ryman rest home and hospital care booklet, a comprehensive information booklet, which forms part of the admission agreement.</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>The service has a policy that describes guidelines for death, discharge, transfer, documentation and follow-up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities and communication with family is made.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. The service uses individualised blister packs for regular and as required (PRN) medications. Medication reconciliation is completed by an RN on delivery of medication and any errors fed back to pharmacy. All medications were securely and appropriately stored on day of audit. There are weekly and six monthly controlled drug checks.</p> <p>All clinical staff who administer medication have been assessed for competency on an annual basis. Education around safe medication administration has been provided.</p> <p>Sixteen medication charts were reviewed. Medication profiles reviewed</p>

		<p>were legible, up to date and reviewed at least three monthly by the GP where required. All medication charts reviewed have as needed medications prescribed with an individualised indication for use. The medication folders include a list of specimen signatures.</p> <p>Staff were observed to be safely administering medications. Senior care staff interviewed, who administer medications, were able to describe their role concerning medicine administration. Standing orders are not used. There were no self-medicating residents.</p> <p>The medication fridge temperatures are recorded weekly and these are within acceptable ranges.</p> <p>There is a signed agreement with the pharmacy.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>All meals are cooked on site. The Ryman menus are implemented and these have been audited and approved by an external dietitian. The cook has copies of dietary information for all residents and is notified of any special dietary needs. Special diets and alternatives for dislikes are accommodated. The cook advised that choices are always available and residents interviewed agreed that the kitchen is very accommodating to changes in preferences</p> <p>End cooked food temperatures are recorded on each meal daily. Serving temperatures from bain-maries are monitored. Temperatures are recorded on all chilled and frozen food deliveries. Fridges and freezer temperatures are monitored and recorded daily. All foods are dated in the chiller, fridges and freezers. Dry goods are stored in dated sealed containers. Chemicals are stored safely. Cleaning schedules are maintained.</p> <p>Food services staff have complete on-site food safety education and chemical safety</p> <p>Residents and family interviewed praised the meals.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>The right to appeal against assessment outcome policy states the manager will inform the resident/family of other options. The service records the reason for declining service entry to residents should this occur and communicates this to residents/family/whanau. Anyone declined entry was referred back to the Needs Assessors or referring</p>

		agency for appropriate placement and advice.
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>The facility has embedded the interRAI assessment protocols within its current documentation. InterRAI initial assessments and assessment summaries were evident in printed format in the seven long term resident files reviewed (one was a short term admission). Files reviewed identified that risk assessments have been completed on admission and reviewed six monthly as part of the evaluation. Additional assessments were appropriately completed according to need. For the resident files reviewed, formal assessments and risk assessments were in place and reflected into care plans.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Care plans reviewed were comprehensive and demonstrated service integration and input from allied health. All resident care plans sampled were resident centred and support needs were documented in detail. Changes in health status were documented on the computer software and formed part of the long term care plan. Evaluation of short term care needs was documented as needed. There was evidence of service integration with documented input from a range of specialist care professionals. One respite resident files reviewed included an initial assessment, a short term care plan that reflected the resident's risks and regular progress notes.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>All care plans reviewed included interventions that reflected the resident's current needs. When a residents condition changes the RN initiates a GP visit. Residents and interviewed reported their needs were being met. Family members interviewed stated the care and support met their expectations for their relative. There was documented evidence of relative contact for any changes to resident health status.</p> <p>Wound assessments, treatment and evaluations were in place for all current wounds, (four skin tears and two pressure injuries). There are two residents with grade two pressure areas (both facility acquired). Pressure injury prevention strategies are included in the long term care plan. GPs are notified of all wounds. Adequate dressing supplies were sighted in the treatment room. Staff receive regular education on wound management.</p> <p>Continence products are available and resident files include a three day</p>

		<p>urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described by the RN's interviewed.</p> <p>Monitoring forms were paper and software based, and had been consistently completed as needed. Unintended weight loss was noted to be monitored and well managed.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The service employs an activity coordinator Monday to Friday for 43 hours per week. The activity coordinator is very experienced in her role.</p> <p>Ryman has reviewed its activity programme and introduced the Ryman Engage programme. A structured approach to activities aims to encompass all aspects of wellbeing for all aspects of life. Staff training has been implemented around the engage process. Residents were informed on a one on one basis, and the new programme rolled out September 2014. Over 2014 and 2015, the service has seen a steady increase in activity attendance up until December 2015.</p> <p>The activity programme is varied and includes community links. Residents have enjoyed many new experiences such as specific men's activities. Other initiatives have included inter home competitions, cooking, baking, men's club and coffee clubs.</p> <p>Contact is made and one on one time spent with residents who are unable to participate in group activities or choose not to be involved in the activity programme. There are regular outings/drives for all residents (as appropriate) and involvement in community events</p> <p>A record is kept individual residents activities. Activity staff complete recreational progress notes in the residents' files. The activity plan in the files reviewed had been evaluated at least six monthly with the care plan review. The resident/family/whanau as appropriate are involved in the development of the activity plan.</p> <p>Resident meetings were held bi-monthly and open to families to attend.</p> <p>The resident and relative satisfaction surveys from February 2014-February 2015 evidenced an increase in satisfaction with the activity programme and the village has continued to rank in the top percentile of Ryman villages. Ranking within the Ryman Group for relative's</p>

		satisfaction ranked number 2 out of 26 Ryman villages in September 2015 for satisfaction with the activity programme.
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	Care plans reviewed had been evaluated by registered nurses' six monthly or when changes to care occurred. Family are informed of any changes as needed. Care plans for short-term needs were evaluated and either resolved or added to the long-term care plan as an on-going problem. There is at least a three monthly review by the medical practitioner. The family members interviewed confirmed they are kept fully informed multidisciplinary care plan reviews and GP visits.
<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	Referral to other health and disability services is evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where a resident's condition had changed and the resident was reassessed for a higher or different level of care. Discussion with the clinical manager identified that the service has access to a wide range of support either through the GP, Ryman specialists and contracted allied services.
<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	There were implemented policies to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles were available and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals were labelled correctly and stored safely throughout the facility. Safety data sheets were available.
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	The building has a current building warrant of fitness that expires on 2 December 2016 and covers the serviced apartments and independent living building adjacent to the rest home area. The rest home area is a single storey building with two wings. The serviced apartments occupy the lower two floors of an eight storey retirement living complex adjacent to the rest home. There are two lifts and stairway access between the levels in the retirement village complex. All 32 serviced apartments in the retirement village complex have now been assessed as suitable to provide rest home level care.

		<p>A maintenance staff member addresses maintenance requests and maintains a 12 monthly planned maintenance schedule. Electrical testing, annual calibration, and functional checks of medical equipment has been completed.</p> <p>Hot water temperatures in resident areas are monitored and recorded. Contractors are available for essential services.</p> <p>The facility has wide corridors with sufficient space for residents to mobilise using mobility aids. The service employs grounds and garden staff that maintain the external areas. Residents were observed to safely access the outdoor gardens and courtyards safely. Seating and shade is provided. The care assistants and RNs interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans.</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>	FA	<p>All bedrooms in the rest home are single occupancy and have toilets and hand basins. All serviced apartments have a bathroom. There are sufficient communal showers located in either wings of the rest home. Further communal toilets are provided in close proximity to lounge and dining areas. Toilets have privacy locks. Residents interviewed confirmed their privacy was assured when staff were undertaking personal cares.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>All residents' rooms were of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Residents are encouraged to personalise their bedrooms.</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>Each serviced apartment has an open plan lounge and dining area. There were other lounges and rooms available in the retirement village complex for quiet private time or visitors. The rest home has a large dining room and two large lounges. The communal areas were easily and safely accessible for residents.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is</p>	FA	<p>The Ryman group has documented systems for monitoring the effectiveness and compliance of the cleaning and laundry service. Laundry and cleaning audits were completed as per the internal audit</p>

<p>being provided.</p>		<p>programme. The laundry had an entry and exit door with defined clean/dirty areas. There are multiple areas for storing cleaning equipment.</p> <p>There is a secure area for the storage of cleaning and laundry chemicals for the laundry.</p> <p>There are dedicated cleaning and laundry persons on duty each day. All linen and personal clothing is laundered on-site. Residents interviewed stated they were happy with the cleanliness of their bedrooms and communal areas. Residents also confirmed their clothing was treated with care and returned to them in a timely manner. The implementation of a laundry labeller system and individualised clothing bags per resident has reduced the amount of missing items of clothing and is increasing resident and relative satisfaction to the point where there were no complaints about missing clothing.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>There are emergency and disaster manuals to guide staff in managing emergencies and disasters. Emergency management, first aid and CPR are included in the mandatory in-service programme. There was a first aid trained staff member on every shift. The Village has an approved fire evacuation plan and fire drills occur six monthly. Smoke alarms, sprinkler system and exit signs are in place. Emergency lighting and cooking facilities are in place. There are civil defence kits in the facility and stored water on site. The call bell system is evident in resident's rooms, lounge areas, and toilets/bathrooms.</p> <p>Serviced apartments have a call bell system, which is linked to staff pagers, and to the call bell panels in the rest home. A staff member is on duty in the serviced apartments between 0700 hours and 2200 hours. Overnight, the serviced apartment call system is linked to rest home staff pagers. Advised by management that two hourly checks are also conducted in the serviced apartment area overnight. Staffing levels can be adjusted in line with the number of rest home residents in the serviced apartment area.</p> <p>Staff advise that they conduct security checks at night, in addition to an external contractor.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p>	<p>FA</p>	<p>General living areas and resident rooms are appropriately heated and</p>

<p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>		<p>ventilated. There are electric wall heaters in SA and communal areas underfloor heating in RH rooms. All rooms have external windows with plenty of natural sunlight. The site is smoke free.</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>	<p>FA</p>	<p>The infection prevention and control programme was appropriate for the size and complexity of the service. An infection prevention and control responsibility policy included a chain of responsibility and an infection prevention and control officer's job description. The infection prevention and control programme was linked into the quality management system via the RAP. The infection prevention and control committee was combined with weekly clinical and management meetings. The facility meetings also include a discussion of infection prevention and control matters. The programme is set out annually from Ryman Christchurch and directed via the Ryman calendar. The facility had developed links with the GP's, local Laboratory, the infection control and public health departments at the local DHB. The clinical manager is the designated infection control lead person for the service.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The infection prevention and control committee (as part of the weekly clinical and management meetings) discusses each resident with identified infection each week and monitors progress. Infection control is also reported to the staff meetings so that all staff are aware of infections and any action plans associated with infection control. The facility also has access to an infection prevention and control nurse specialist from the DHB, public health, GP's and expertise from within the organisation.</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>	<p>FA</p>	<p>There are comprehensive infection prevention and control policies that are current and reflect the Infection Prevention and Control Standard SNZ HB 8134:2008, legislation and good practice. These policies are generic to Ryman and the templates were developed by an external agency. The infection prevention and control policies link to other documentation and cross reference where appropriate.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control</p>	<p>FA</p>	<p>The infection prevention and control officer is responsible for coordinating/providing education and training to staff. The infection prevention and control officer has completed online e-learning infection</p>

<p>to all service providers, support staff, and consumers.</p>		<p>prevention and control training since commencing in the role. The orientation/induction package includes specific training around hand washing and standard precautions and training is provided both at orientation and as part of the annual training schedule. Resident education occurs as part of providing daily care.</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>	<p>CI</p>	<p>The surveillance policy describes the purpose and methodology for the surveillance of infections. Definitions of infections are in place appropriate to the complexity of service provided. Individual infection report forms are completed for all infections and kept as part of the resident files. Weekly infection control reports are reported to the clinical /management meeting and monthly reports to the staff meetings and the Ryman benchmarking process.</p> <p>The infection prevention and control programme is linked with the Ryman quality programme. The infection prevention and control officer uses the information obtained through surveillance to determine infection prevention and control activities, resources, and education needs within the facility. There is close liaison with the GP's that advise and provide feedback /information to the service. Internal infection control audits also assist the service in evaluating infection control needs.</p> <p>Infections statistics are included for benchmarking. Corrective actions are established where trends are identified.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. The policies and procedures are comprehensive, and include definitions, processes and use of restraints and enablers. On the day of audit, there were no residents with restraint or enablers.</p> <p>Staff training has been provided around restraint minimisation and enablers, falls prevention and analysis, and management of challenging behaviours.</p>

Specific results for criterion where corrective actions are required

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

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

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

No data to display

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
<p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>The achievement of the rating that service provides an environment that encourages good practice is beyond the expected full attainment. The service has conducted a number of quality improvement projects where a review process has occurred, including analysis and reporting of findings. There is evidence of action taken based on findings that has made improvements to service provision. The projects include reviewing whether improvements have had positive impacts on resident safety or resident satisfaction.</p>	<p>The service identified they wanted to make an improvement around the reduction of falls. Quality improvements identified through the analysis and trending of data included reducing the number of falls in bedrooms. Data was collected monthly over a period of one year with six monthly analysis reports. Staff were kept informed through handovers and regular meetings. Data results for falls identify the service have successfully reduced the number of accidents/incidents for falls. Staff interviewed were knowledgeable in the prevention and appropriate interventions to prevent falls and embedded these practices in their daily resident cares and working environment (link CI 1.2.3.6).</p> <p>Frances Hodgkins ranked number 1 out of 26 Ryman healthcare villages from April 2015-April</p>

			<p>2016 for the lowest rates of challenging behaviour reported within the Ryman Group at 0.01 per 1000 bed nights. An evaluations process identified the low rate is attributed to the low turnover of staff, continued education for staff, the “getting to know your resident education evidencing more personalised behavioural management plans and the implementation of the Engage activities programme offering a variety of new activities that interest and engage the residents.</p> <p>Frances Hodgkins has achieved consistently high rankings within the Ryman Group in regards to resident satisfaction. The service actively initiates corrective actions in response to resident feedback through meetings and surveys. Outcomes are shared with residents. Evaluation of outcomes identified that; (i) May 2014 Ranked 5th out of 23 villages in resident satisfaction survey; (ii) February 2015 ranked 9th out of 27 villages in the resident satisfaction survey; and (iii) February 2016 ranked 4th out of 27 villages in the resident satisfaction survey.</p> <p>A corrective action plan was implemented around managing residents with weight loss. Actions included (but not limited to); review of weight loss and residents at risk at meetings, discussions with staff on nutritional requirements of residents, reviewing and monitoring that residents at risk had early intervention to prevent or manage weight loss quickly. The evaluation process identified that there were 13 residents who were identified at risk of malnutrition. Of the ten residents noted at risk, none have had unintentional weight loss of 5% in 3 months and none have had unintentional weight loss of 10% in last six months. Four of the ten residents have gained weight between 2.5% - 11.8%</p>
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			within the last six months and remaining six have maintained their weight over the last six months.
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	CI	<p>Robust systems are in place for the collection, analyses, and evaluations of quality data. Results are communicated to staff via a variety of forums. A range of data is collected across the service using V-care, an electronic data system. Data is collated and analysed with comprehensive evaluation reports completed six monthly. Data analysis is enhanced using control charts, which identifies normal variation, patterns and trends. Data is benchmarked against other Ryman facilities. Communication of results occurs across a range of meetings across the facility (e.g., management meetings, full facility meetings, care assistant meetings). Templates for all meetings document action required, timeframe, and the status of the actions.</p>	<p>Data collated is used to identify any areas that require improvement. The quality programme for 2016 includes objectives for improving outcomes for residents. Clinical indicator data has individual reference ranges for acceptable limits and levels of incidents and infections. Data is collected around falls, skin tears, pressure injuries, and infections.</p> <p>Falls were identified as an area that required improvement from data collected from 2014. A plan was developed in February 2015 which included identifying residents at risk of falling, providing falls prevention training for staff, reviewing call bell response times, reviewing the roster to ensure adequate supervision of residents, encouraging resident participation in the activities programme, and reviewing of clinical indicator data. Further initiatives implemented included routine checks of all residents specific to each resident's needs (intentional rounding), the use of sensor mats, night lights, proactive and early GP involvement, and increased staff awareness of residents who are at risk of falling. Care assistants interviewed were knowledgeable in regards to preventing falls and those residents who were at risk. The plan has been reviewed monthly and discussed at staff meetings. Education and training for staff has been provided in 2015 and for new staff as part of orientation.</p> <p>Falls rates remained between the reference range of 3.3 and 11 per 1000 occupied bed days between February 2015 and January 2016. The</p>

			rate of falls in November 2015 and January 2016 were below 3.3.
<p>Criterion 1.2.7.4</p> <p>New service providers receive an orientation/induction programme that covers the essential components of the service provided.</p>	CI	<p>A comprehensive orientation programme has been implemented for new staff. A Ryman initiative around staff orientation was developed in late 2014.</p>	<p>Frances Hodgkins has embedded the Ryman orientation programme for new staff. The purpose of the programme is to create a welcoming and structured orientation process for new staff to ensure that they feel welcomed, supported, confident and competent in their roles. The ultimate outcome is improvement of care for residents and low staff turnover. Issues had also arisen with staff not completing their orientation.</p> <p>The service developed a site specific action plan, which included the creation of an orientation plan, receiving feedback from new staff on the orientation process, and discussion with staff at staff meetings. An induction day plan has been developed which includes a specific day where new staff are orientated to the service. Actions taken included the development of a revised orientation pack for all new staff, designation of orientation 'buddies' within all departments to ensure there is continual support and guidance for all new staff, provision of education and training for the buddies on the expectations of their roles, and the development of an orientation plan for the orientation period.</p> <p>Evaluation of this quality initiative has been undertaken via monitoring the percentage of staff completing their inductions and analysis of feedback received from new staff post orientation. The percentage of staff completing inductions has increased from 90% (end 2014) to 100% (end 2015). Feedback from staff via staff surveys on the usefulness of their orientation is positive. They report that they feel</p>

			<p>confident and competent to undertake their role. Furthermore, comments around the length of orientation time is taken into consideration for each employee based on their level of skill and confidence in their role and is adjusted as required from three to five days. The resident survey conducted in February 2016 evidenced that resident satisfaction with the way staff care, and staff communication, has improved.</p>
<p>Criterion 3.5.1</p> <p>The organisation, through its infection control committee/infection control expert, determines the type of surveillance required and the frequency with which it is undertaken. This shall be appropriate to the size and complexity of the organisation.</p>	CI	<p>The infection prevention and control programme is linked with the Ryman quality programme. The infection prevention and control officer uses the information obtained through surveillance to determine infection prevention and control activities, resources, and education needs within the facility. Infections statistics are included for benchmarking. Corrective actions are established where trends are identified.</p>	<p>Quality improvement plans are established when the service is above the benchmark. Examples were sited where Frances Hodgkin's had implemented corrective actions when UTI's increase. Frances Hodgkin's ranked 4th out of 26 Ryman Healthcare villages for the lowest rates of UTIs reported at 1.43 per 1000 bed nights from April 2015- April 2016 which is below the NZ national benchmarking reference range of 1.5 per 1000 bed nights. The clinical indicator data and benchmarking results for the group evidence that Frances has been able to sustain this low rate of UTIs from 2014- 2016. April 2014-April 2015 data evidences they were ranked 4th within the group with a total of 1.45 per 1000 bed nights.</p>

End of the report.