

# Frances Hodgkins Retirement Village Limited - Frances Hodgkins Retirement Village

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## 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 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: 31 May 2018 End date: 31 May 2018

**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:** 53



# Executive summary of the audit

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## 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 a Ryman healthcare retirement village. The service provides rest home level care across a care centre and in serviced apartments. The care centre can accommodate up to 51 rest home residents and there are also 32 serviced apartments that are certified for rest home level care. On the day of audit there were 53 residents in total.

This unannounced surveillance audit was conducted against a sub-set of 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 the general practitioner.

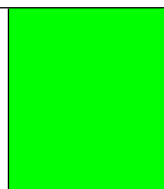
The service is managed by a village manager and clinical manager. Both are experienced in aged care and are supported by a regional manager. Staff levels remain stable. The residents and family member interviewed spoke positively about the care and support provided.

The service continues to implement a quality and risk management programme.

The previous continuous improvements awarded at their last audit around falls prevention programme and infection surveillance continue to attain a continuous improvement rating.

## 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.

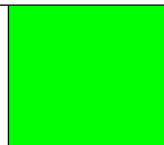


Standards applicable to this service fully attained.

Regular contact is maintained with families, including if a resident is involved in an incident or has a change in their current health. Relative and resident meetings are held regularly. A system for managing complaints is in place. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service.

## 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.

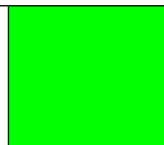


Standards applicable to this service fully attained.

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 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. An orientation programme is in place for new staff. Ongoing education and training for staff 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.

## 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.

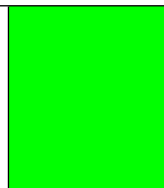


Standards applicable to this service fully attained.

InterRAI assessments, risk assessments, care plans, interventions and evaluations are completed by the registered nurses. Care plans demonstrate service integration. Residents and family interviewed confirmed they were involved in the care plan process and review. Care plans were updated for changes in health status. The general practitioner completes an admission visit and reviews the residents at least three-monthly. The activity team provide an activities programme which is varied and interesting. The activities programme meets the abilities and recreational needs of the group of residents. Residents are encouraged to maintain links with community groups. 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. The general practitioner reviews medications three-monthly. The menu is designed by a dietitian at an organisational level. All baking and meals are cooked on-site. Individual and special dietary needs are accommodated.

## 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.

A current building warrant of fitness is posted in a visible location.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.

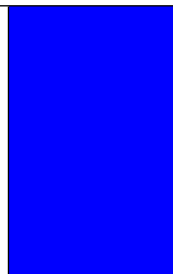


Standards applicable to this service fully attained.

The service has 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 training around restraint minimisation and enablers.

## Infection prevention and control

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



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 prevention and control is included in integrated meetings with the quality team. Infection surveillance is completed, and a monthly infection control report is correlated and forwarded to head office for analysis and benchmarking. Two outbreaks have been well managed.

## 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)
<b>Standards</b>	1	15	0	0	0	0	0
<b>Criteria</b>	2	39	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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 1.1.13: 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 and located in a visible location. Information about complaints is provided on admission. Interviews with all residents and family member confirmed their understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints. There is a complaint register that includes written and verbal complaints, dates and actions taken and demonstrates that complaints are being managed in a timely manner. The complaints process is linked to the quality and risk management system. Three complaints have been received since the last audit, one complaint received in 2016 and two made in 2017, and there have been no complaints received in 2018 year-to-date. All complaints have been managed in a timely manner and are documented as resolved.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an</p>	FA	<p>Five residents interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. Ten incidents/accident forms reviewed include a section to record family notification. All forms evidenced family were informed or if family did not wish to be informed. One relative interviewed confirmed that they are notified of any changes in their family member's health status. Two monthly residents' and six monthly relative meetings provide a forum for residents and families to discuss any issues or concerns. An interpreter policy and contact details of interpreters is available. Interpreter services are used where indicated.</p>

environment conducive to effective communication.		
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>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 full occupancy of 51 residents on the day of audit. This included one hospital level resident. Dispensation letter from the Ministry of Health (dated 29 May 2018) with the expiry date of 23 August 2018 was sited. All other residents are under the age related residential care (ARRC) contract. There are 32 serviced apartments adjoining the care centre that are certified for rest home level care. The apartments are part of an eight storey, retirement village complex adjacent to the rest home. There were two rest home level residents in the serviced apartments at the time of the audit.</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 2018 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 2018 objectives.</p> <p>The village manager at Frances Hodgkins has been in the role for ten years and is a registered nurse (RN). She is supported by an experienced clinical manager who oversees clinical care and has been in the position for 12 years. The management team is supported by the wider Ryman management team that includes a regional manager.</p> <p>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 1.2.3: 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</p>	FA	<p>Frances Hodgkins has an 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 and review of management and staff meeting minutes, demonstrated their involvement in quality and risk activities. Resident meetings are held two-monthly in each wing and family meetings are held six-monthly. Annual resident and relative surveys are completed, last in February and March 2017. Results were fed back to staff and participants through meetings and village reports to relatives. At the time of the audit the results for the 2018 resident and relative satisfaction surveys had not been completed.</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. The quality monitoring programme is designed to monitor contractual and standards compliance and the quality of service delivery. Management systems have been implemented and regularly reviewed including an internal audit programme. Quality improvement plans are</p>

<p>principles.</p>		<p>implemented for audit outcomes less than 90%. Re-audits are completed as required. The facility has implemented processes to collect, analyse and evaluate data including infection control, accidents/incidents, complaints which are 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. The health and safety officer (caregiver) was interviewed. She has completed external health and safety training. Health and safety meetings are conducted bi-monthly. Risk management, hazard control and emergency policies and procedures are in place. 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. Falls prevention strategies are in place that include; ongoing falls assessment, reviewing call bell response times, routine checks of all residents specific to each resident's needs (intentional rounding), encouraging resident participation in the activities programme and the use of sensor mats and night lights. 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>	<p>FA</p>	<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. Ten incidents/accidents forms reviewed for April and May 2018 identified that all are fully completed and include follow-up by a RN. Neurological observations had been completed where there was a suspected injury to the head. The clinical manager is involved in the adverse event process, with links to the regular management meetings and informal meetings. This provides the opportunity to review any incidents as they occur. The village manager was able to identify situations that would be reported to statutory authorities. There have been no section 31 notifications made since the last audit. The service notified public health in relation to two outbreaks in 2017 (link 3.5).</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management</p>	<p>FA</p>	<p>There are human resources policies including recruitment, selection, orientation and staff training and development. Five staff files reviewed (one clinical manager, one serviced apartments coordinator, two caregivers and one activities coordinator) 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. A register of RN practising certificates is maintained within</p>

<p>processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>the facility. Practicing certificates for other health practitioners are retained to provide evidence of registration.</p> <p>The orientation programme provides new staff with relevant information for safe work practice. There is an implemented annual education plan. Staff training records are maintained. 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. Registered nurses are supported to maintain their professional competency. There are four RNs (including the village manager and clinical manager), two of four RNs have completed their interRAI training. There are implemented competencies specific to RNs and caregivers related to specialised procedures and/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. The village manager and clinical manager, work full time and are on call 24/7. In the care centre there are 51 rest home residents. There is a RN on the morning shift who is supported by five caregivers on duty on the morning shift, four caregivers on duty on the afternoon shift and two caregivers on duty on the night shift. There were two rest home residents in the serviced apartments. In the serviced apartment there is a serviced apartment coordinator who is supported by one caregiver on duty on the morning shift and two caregivers on the afternoon shift, with one caregiver from the care centre 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. 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 member interviewed reported there are adequate staff numbers.</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>	<p>FA</p>	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. Medicine management complies with Ministry of Health medication requirements. Medication reconciliation of monthly blister packs is completed by an RN and any errors are fed back to pharmacy. Registered nurses and senior caregivers who administer medications have been assessed for competency on an annual basis. Care staff interviewed were able to describe their role in regard to medicine administration. Senior care staff observed on medication rounds followed correct procedures. Education around safe medication administration has been provided.</p> <p>All medications were securely and appropriately stored on day of audit. There are weekly and six monthly controlled drug checks. Medication fridges were monitored weekly. All eye drops, and creams were dated on opening. Residents have photo identification on medication charts and allergies are recorded. Two self-medicating residents had been assessed and reviewed by the GP and RN as competent to self-administer. Ten electronic medication charts (one hospital and nine rest home) were reviewed and evidenced that all medication documentation has been completed appropriately including charting and administration signing. The effectiveness of 'as required'</p>

		medications is recorded in progress notes.
<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>	FA	<p>All food and baking are prepared and cooked on-site. The qualified head chef is supported by a weekend cook and kitchen assistants. Staff have been trained in food safety and chemical safety. There is an organisational four-weekly seasonal menu that had been designed in consultation with the dietitian at organisational level. Meals are served from bain maries directly to residents in the attached dining room. The cook receives a resident dietary profile for all new admissions and is notified of any dietary changes. Resident likes, dislikes and dietary preferences were known. Alternative foods are offered.</p> <p>Cultural, religious and food allergies are accommodated. Special diets such as pureed/soft diets are provided. Freezer and chiller temperatures and end-cooked temperatures are taken and recorded twice daily. Chilled goods temperature is checked on delivery. Twice daily food temperatures are monitored and recorded. All foods were date labelled. A cleaning schedule is maintained. Staff were observed to be wearing appropriate personal protective clothing. Residents interviewed were complimentary around the food service.</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>Residents interviewed reported their needs were being met. The family member interviewed stated their relative's needs were being appropriately met. When a resident's condition alters, a RN initiates a review and if required, a GP visit or nurse specialist consultant. Electronic care plans reviewed were updated to reflect the changes in resident needs/supports. Short-term care plans are generated through completing an updated assessment on myRyman (electronic system), and interventions are automatically updated into the care plan. Evaluations of the assessment when resolved completes the short-term care plan. The hospital resident's (one with a current dispensation) assessed needs were documented and implemented. Wound assessments, treatment and evaluations were in place (on the electronic database) for eight residents with wounds (two skin tears, one stage one, and one stage two pressure injuries and four chronic ulcers). Adequate dressing supplies were sighted in the treatment rooms.</p> <p>The RNs described access to the DHB wound nurse, district nurse and vascular clinic as required. The GP reviews wounds three-monthly or earlier if there are signs of infection or non-healing. Chronic wounds and pressure injuries are linked to the long-term care plans.</p> <p>Contenance products are available and resident files include a three-day 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 RNs interviewed. Monitoring in myRyman include (but not limited to): monthly weight, blood pressure and pulse, neurological observations post unwitnessed falls or identified head injuries, food and fluid charts, restraint monitoring, pain monitoring, blood sugar levels and behaviour charts. Electronic progress notes document changes in health and significant events.</p>

<p><b>Standard 1.3.7: Planned Activities</b></p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The service employs an experienced activity coordinator (AC) Monday to Friday for seven hours a day and an apartment activities coordinator. The rest home activity coordinator is supported by the apartment activities coordinator for five hours a week. The team of two activities staff coordinate and implement the Engage programme across the two areas; rest home and serviced apartments. Activity staff attend on-site and organisational in-service training relevant to their roles. The activities staff have current first aid certificates. Activity assessments are completed for residents on admission. A record is kept of individual resident's activities. Contact is made, and one-on-one time spent with residents who are unable to participate in group activities (including the resident assessed as hospital level care) or choose not to be involved in the activity programme.</p> <p>The activity plan in five of the six files reviewed had been evaluated at least six-monthly with the care plan review. One resident did not require an evaluation. The resident/family/whānau as appropriate are involved in the development of the activity plan. Residents/relatives have the opportunity to feedback on the programme through the resident meetings and satisfaction surveys. The Engage programme has set activities with the flexibility for each service level to add activities that are meaningful and relevant for the resident group including Triple A exercises, walking groups, themes events and celebrations, baking and cooking, crafts, games, entertainment, outings and a weekly van outing. Community involvement includes entertainers, school group visits and church services. Activities are provided Monday to Friday in the rest home with a separate programme implemented in the apartment unit.</p>
<p><b>Standard 1.3.8: Evaluation</b></p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Long-term care plans reviewed had been evaluated by a RN for long-term residents who had been at the service six months. One apartment unit resident does not yet require an evaluation. Electronic evaluations for long-term residents describe the resident's progress against the resident's identified goals and any changes are updated on the long-term care plan. The multidisciplinary review involves the RN, clinical manager, GP, caregiver, activities staff and other allied health professionals involved in the care of the resident. The family are notified of the outcome of the review if unable to attend. There is at least a three-monthly review by the medical practitioner. The family member interviewed confirmed they had been invited to attend the multidisciplinary care plan reviews and GP visits.</p>
<p><b>Standard 1.4.2: Facility Specifications</b></p> <p>Consumers are provided with an appropriate, accessible physical</p>	FA	<p>The building has a current building warrant of fitness that expires on 2 December 2018. Reactive and preventative maintenance occurs. The environment is safe and meets the needs of the residents.</p>

environment and facilities that are fit for their purpose.		
<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>	CI	<p>The surveillance policy describes the purpose and methodology for the surveillance of infections. Definitions of infections are appropriate to the complexity of service provided. Individual infection report forms are completed for all infections and are kept as part of the resident files. Infections are included on an electronic register and the infection prevention and control officer (RN) completes a monthly report. Monthly data is reported to the combined infection prevention and control/health and safety meetings. Staff are informed through meetings held at the facility. The infection prevention and control programme links with the quality programme.</p> <p>There is close liaison with the GPs and laboratory service that advise and provide feedback and information to the service. Systems in place are appropriate to the size and complexity of the facility. The service has had two outbreaks in 2017 (both norovirus). Relevant authorities were notified, and documentation completed daily. Staff were kept informed at handovers and by daily memos. All staff received an educational debrief. Infection control policy and practice meets best practice. The service has continued to exceed the standard around infection control.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Restraint practices are only used where it is clinically indicated and justified, and other de-escalation strategies have been ineffective. The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. On the day of audit, there were no residents with restraint or enablers. Staff training has been provided around restraint minimisation and enablers.</p>

## Specific results for criterion where corrective actions are required

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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
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## Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<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. A range of data is collected around (but not limited to) falls, skin tears, pressure injuries, and infections across the service through myRyman. Data collated is used to identify any areas that require improvement. Clinical indicator data has individual reference ranges for acceptable limits and levels of incidents and infections. Data is benchmarked against other Ryman facilities. Communication of results occurs across a range of meetings across the facility (e.g., management, full facility and clinical/RN meetings). Templates for all meetings document action required, timeframe, and the status of the actions.</p>	<p>Falls were identified as an area that required improvement from data collected from 2016. A continuous improvement plan was developed in December 2016, which included identifying residents at risk of falling, reviewing call bell response times, routine checks of all residents specific to each resident’s needs (intentional rounding), reviewing the roster to ensure adequate supervision of residents, encouraging resident participation in the activities programme, reviewing of clinical indicator data, the use of sensor mats and night lights, proactive and early GP involvement, and increased staff awareness of residents who are at risk of falling.</p> <p>The plan has been reviewed monthly and discussed at management, staff and clinical meetings. Education and training for staff has been provided in 2017 and for new staff as part of orientation.</p>

			Caregivers interviewed were knowledgeable in regard to preventing falls and those residents who were at risk. The outcome of the plan has been that falls rates in November 2016 were at 10.4 per 1000 bed nights, the rate of falls continued to reduce within the 2017 period with the rates in January 2018 being at 3.4 per 1000 occupied bed nights.
<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 use the information obtained through surveillance to determine infection prevention and control activities, resources, and education needs within the facility. Corrective actions are established where trends are identified.</p>	<p>Quality improvement plans are established when the service is above the benchmark. Francis Hodgkins has continued to maintain and reduce UTI infections rates well below the NZ national benchmarking reference rate of 1.5 per 1000 bed nights. Aside from a spike (related to a new resident) the highest UTI rate during 2017 and year-to-date was 1.41 per 1000 bed nights and the lowest was 0.64 from August to November. The clinical indicator data and benchmarking results for the group evidence that Frances Hodgkins has been able to sustain this low rate of UTIs. Strategies to reduce UTI's are regularly evaluated.</p>

End of the report.