McKenzie Healthcare Limited

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:	McKenzie Healthcare Limited
Premises audited:	McKenzie HealthCare
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 8 August 2016 End date: 9 August 2016

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 49

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

McKenzie Healthcare is a privately owned aged care facility situated in South Canterbury. The company has five shareholders and directors.

The service is certified to provide rest home, hospital and dementia level care for up to 50 residents. On the day of the audit, there were 49 residents.

This unannounced surveillance audit was conducted against a subset of the Health and Disability standards and the contract with the district health board. The audit process included a review of policies and procedures; the review of residents' and staff files, observations and interviews with residents, relatives, staff and management.

A chief operations officer/nurse manager oversees the service and is suitably qualified. Feedback from residents and relatives is positive.

Seven of the ten shortfalls identified at the previous audit have been addressed. These were around corrective actions, security of resident files, use of short-term care plans, medication documentation, and completion of the new dementia unit. Further improvements continue to be required around signed consents, care plan documentation and interventions.

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.		Some standards applicable to this service partially attained and of low risk.

Residents and family are well informed regarding changes in resident's health. Management team have an open door policy. Complaints processes are implemented, and complaints and concerns are managed and documented and learning's from complaints shared with all staff.

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.

McKenzie Healthcare has an established quality and risk management system that supports the provision of clinical care and support. An annual resident/relative satisfaction survey is completed and there are regular resident/relative meetings. Incidents are documented and there is immediate follow up from a registered nurse. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has in place an orientation programme that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care and support and external training is supported. The organisational staffing policy aligns with contractual requirements and includes skill mixes.

Continuum of service delivery

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

Resident records reviewed provide evidence that the registered nurses utilise the InterRAI assessment to assess, plan and evaluate care needs of the residents. Care plans are developed in consultation with the resident and/or family. Care plans demonstrate service integration and are reviewed at least six monthly. Resident files include three monthly reviews by a general practitioner. There is evidence of other allied health professional input into resident care.

Medication policies reflect legislative requirements and guidelines. All staff responsible for administration of medicines complete education and medicines competencies. The medication records reviewed included documentation of allergies and sensitivities and are reviewed at least three monthly by the general practitioner.

There are activities programmes in place for the rest home, dementia unit and hospital residents. The programme includes community visitors and outings, entertainment and activities that meet the recreational preferences and abilities of the residents.

All food and baking is done on site. All residents' nutritional needs are identified and documented. Choices are available and are provided.

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.

The building holds a current warrant of fitness.

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.

A restraint policy includes comprehensive restraint procedures including restraint minimisation. A documented definition of restraint and enablers aligns with the definition in the standards. There is one restraint and nine enablers being used. Enabler use is voluntary.

Infection prevention and control

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

The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. Staff receive ongoing training in infection control.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	17	0	1	2	0	0
Criteria	0	45	0	1	2	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	PA Low	A review of five files (one rest home, two dementia and two hospital, including one younger person disabled file) identified that all files reviewed included general consents. There were admission agreements sighted in all five files, which were signed by the resident or nominated representative, which is an improvement from the previous audit. Discussion with three families identified that the service actively involves them in decisions that affect their relatives' lives. The service is in the process of introducing the DHB approved resident consent forms. Forms included a wide range on areas for consent including advanced directives transport, and photographs. Not all files had resuscitation consent forms completed and signed.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints procedure is provided to resident/relatives at entry and is prominent around the facility on noticeboards. A complaint management record is completed for each complaint. A record of all complaints per month is maintained by the facility using the complaint register. There were two complaints for 2016. Documentation, including follow-up letters and resolution, demonstrated that complaints are well managed. Discussion with residents and relatives confirmed they were provided with information on complaints and complaints forms. One complaint to the Health and Disability Advocacy service around falls during 2016 has been resolved.

Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Six residents (three hospital and three rest home) and three family members (two dementia and one hospital) interviewed stated they were informed of changes in health status and incidents/accidents. Residents and family members also stated they were welcomed on entry and given time and explanation about services and procedures. Nine incident forms all documented communication with families. There are documented family/resident meetings each month with comprehensive information regarding service discussed at meetings. The chief operation officer/nurse manager has an open-door policy. Residents and family were advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The service has policies and procedures available for access to interpreter services and residents (and their family/whānau). If residents or family/whānau have difficulty with written or spoken English, then interpreter services are made available.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	McKenzie Healthcare is privately owned and is governed by five shareholders and company directors. The chief operating officer/nurse manager leads McKenzie Healthcare. She is supported in her role by a team of senior registered nurses (team leaders) and a staff educator. The chief operating officer/nurse manager has been in the role since 2015. There is a documented strategic plan, quality plan and operational plans for the extension of the village. McKenzie Healthcare provides rest home, hospital and dementia level care for up to 50 residents in a 44-bed rest home and hospital wing (all dual-purpose) and a six bed dementia unit. There were 34 hospital level residents and 9 rest home level residents, and 6 dementia residents on the day of the audit. With the exception of two hospital level younger person disabled (YPD) residents, all residents were under the ARRC contract. The nurse manager has completed 86 hours in the past 12 months of professional development related to managing an aged care residential facility.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous	FA	McKenzie Healthcare has an established quality and risk management system. The service has policies and procedures, and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards. Policies are current and staff are informed of updates and changes. Key components of the quality management system link to the monthly team meetings and registered nurse meetings. Monthly team meeting minutes' document that all quality outcomes and data collection is

quality improvement principles.		discussed. There is an internal audit schedule in place and this was documented as followed. Action plans were documented where areas of non-compliance were identified. This is an improvement on the previous audit. There are monthly accident/incident and infection reports provided for rest home, hospital and dementia level care. There is a comprehensive hazard management, health and safety, and risk management programme in place. There are facility goals around health and safety. There is a designated health and safety committee who meet as part of the team meetings and there is a current hazard register. Falls prevention strategies are in place.
Standard 1.2.4: Adverse Event Reporting 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.	FA	The service documents and analyses all incidents/accidents. There is a multi-use form that can be completed for all hazards, near misses and incidents and accidents. Nine resident related incident forms were reviewed. Individual incident reports have been completed for each incident/accident, with immediate action noted. The data is linked to the organisation's health and safety programme trends, and individual resident risks were documented as followed up, All incident forms reviewed documented immediate follow-up by a registered nurse including completion of neurological observations for all unwitnessed falls, or falls with a possible head injury. Care plan interventions and/or short-term care plans were in place where needed following a resident fall. The pressure injury had been reported using the incident form process. Discussions with service management, confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	A register of practising certificates is maintained. Eight staff files were reviewed (three registered nurses including the educator and five caregivers). All files included appropriate employment documentation and up-to-date performance appraisals. The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice, including caring for those with dementia. Staff interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. An annual education schedule is being implemented. Additional training is provided as needed (such as medication software training and documentation training when new processes were rolled out). Registered

		nurses (RNs) are provided with suitable training. A competency programme is in place with different requirements according to work type. There are 14 caregivers including the activities person that work in the dementia unit. All dementia unit staff have completed the required dementia standards. Four additional staff are currently in the process of completing the standards. The service does not allow staff to work in the dementia unit until they have completed the training. All registered nurses have an up-to-date first aid certificate and six of seven RNs are trained in InterRAI.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	An organisational staffing policy aligns with contractual requirements and includes skill mixes. There are at least two registered nurses on duty for the AM and PM shifts and one on a night shift. The chief operating officer/nurse manger is also a registered nurse and works 40 hours per week. Interviews with relatives and residents all confirmed that staffing numbers were appropriate. Caregivers interviewed stated that they have sufficient staffing levels.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	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 containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access. The service has implemented a new process and procedures around the documentation of notes. This involves progress notes being documented each shift and they are legible, dated and signed by the relevant caregiver or nurse including designation. Individual resident files demonstrate service integration. The nurses' station was observed to be secure and residents' private information was not able to be viewed. This is an improvement on the previous audit.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative	FA	The medication process was reviewed for hospital, rest home and dementia residents. The service uses a computerised medication system and charts were fully documented and easy to read. All 'as needed' medication documented included indications for use, this is an improvement on the previous audit. All staff administering medications have completed an annual medication competency. All medications were stored safely and all medication checks and administration meet requirements. Medication administration was observed and the staff member was compliant in the administration of medication. All medications are

requirements and safe practice guidelines.		checked on delivery against the medication chart and discrepancies are fed back to the supplying pharmacy. The 10 medication charts sampled were clear and easy to understand, they included photo ID and allergies. The service facilitates self-medication for residents however, there were no residents self-medicating on the day of audit. All medication charts sampled showed evidence of being reviewed by the GP 3 monthly.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	McKenzie Healthcare continues to provide meals to residents that are prepared and cooked onsite. There are four weekly summer and winter menus with dietitian review and audit of menu conducted. All diets were catered for. Meals were provided in three dining rooms and transported in hotboxes and served fully plated. There were hot food temperatures taken at each meal service and these were recorded. There were sandwiches and snacks available for residents outside of mealtimes. Special eating aids are provided as assessed to promote independence. Food services staff knew resident dietary profiles and likes and dislikes and any changes were communicated to the kitchen via a dietary profile form. Staff were observed wearing appropriate protective clothing. Fridge and freezer temperature monitoring was recorded daily and records sighted. Food was stored safely. Interviews with residents indicate that meals were enjoyed. Staff have been trained in safe food handling.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Moderate	The service uses a largely templated care plan tool. Registered nurses are expected to add to the template and personalise the care plans as needed according to the assessment process. The previous audit documented that care plans had generic typed sections that did not relate to the residents identified needs. The five care plans reviewed for this audit had been adapted and the generic template changed, however not all interventions were documented as needed. Residents and family members interviewed confirm they are involved in the development and review of care plans. There was evidence of service integration with documented input from a range of specialist care.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and	PA Moderate	All resident files reviewed had a documented care plan and care plans documented updates however, not all identified needs have been addressed in care plans (link 1.3.5.2). When a residents condition changes, the RN initiates a GP visit, or nursing specialist referral. Residents 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. Monitoring was not always documented, and wound care plan documentation and timeliness of evaluation was not always

desired outcomes.		documented according to the policy. Continence 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. Caregivers and RNs interviewed state there is adequate continence and wound care supplies. Monitoring charts were utilised; examples sighted included (but not limited to), weight and vital signs, blood glucose, food and fluid, turning charts and behaviour monitoring as required.
Standard 1.3.7: Planned Activities 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.	FA	The activities team at McKenzie Healthcare continues to provide an integrated, varied and well attended activity programme for residents over five days a week. The service employs a DT and four activities coordinators who are based in each of the three units. The activity programme is displayed on noticeboards. There are a range of activities to meet most needs including entertainment, bingo, bowls and games. Church services are held. Variations to the programme are notified to the residents. In the dementia unit, there are activities in place and each resident has a documented 24-hour activity plan. Residents from the dementia unit also attend activities in the rest home or hospital. There are memorabilia available to residents. On the day of audit, activities were seen to be taking place and most residents were actively engaged. The activity assistant has one-on-one time with residents who are unable or who choose not to participate in the programme.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	In files sampled, the registered nurses documented care plan evaluations. Six monthly multi-disciplinary reviews (MDT) were completed by the registered nurse with input from caregivers. Family are invited to attend the MDT review. Files sampled also had short-term care plans available to focus on acute and short-term issues. These were evaluated regularly and signed off as needed. The service has addressed this previous audit finding.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate,	FA	The service has a current building warrant of fitness that expires on 1 July 2017 and has ACC tertiary accreditation expiring 31 August 2016. The planned maintenance schedule in place is fully implemented and includes the calibration of medical equipment and functional testing of electric beds and hoists. The service has a trained electrical tester and

accessible physical environment and facilities that are fit for their purpose.		equipment to carry out annual electrical testing. Hot water temperatures in resident areas are monitored and are between 43-45 degrees Celsius. The facility has wide corridors with sufficient space for residents to mobilise using mobility aids. Residents were able to access the outdoor gardens and courtyards safely. Seating and shade is provided. The service has privacy locks to toilets and bathrooms. There is a large, secure garden area for the dementia wing. The six-bed dementia unit is now secure and entry is via a keypad locking system. The service has addressed the previous partial provisional audit findings around the opening of a new service.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	The service continues to manage an emergency and security system. There are emergency and disaster manuals to guide staff in managing emergencies and disasters. Emergencies, first aid and CPR were included in the mandatory in-service programme. There was a first aid trained staff member on every shift. McKenzie Healthcare has an approved fire evacuation plan, which includes the dementia unit, and there are fire drills monthly. Smoke alarms, sprinkler system and exit signs in place. The service has addressed this previous partial provisional audit finding.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. Individual infection report forms are completed for all infections. Infections are included on a monthly register and a monthly report is completed by the infection control coordinator. Infection control data is collated monthly and reported to team meetings and the infection control programme is linked with the quality management programme. Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GPs that advise and provide feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. The policy includes comprehensive restraint procedures. The process of assessment and evaluation of enabler use is the same as a restraint and included in the policy. There was one resident with restraint in the hospital (a lap belt) and nine residents with enablers (bed rails and or lap belts when in a wheelchair). There is a strong drive to reduce restraints and involve families/EPOA in the process. Review of restraint usage and all restraint and enablers are reviewed monthly. Residents' files for residents with enabler's showed that enabler use is voluntary. One restraint file and two enablers files all included appropriate assessment, consents and monitoring.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.1.10.7 Advance directives that are made available to service providers are acted on where valid.	PA Low	McKenzie Healthcare has policies and procedures relating to informed consent and advanced directives. They are in the process of introducing the DHB approved resident consent forms. Forms included a wide range on areas for consent including advanced directives transport, and photographs. Two of five files had this form completed and signed.	Three of five resident files did not have a signed advanced directive / resuscitation form. One of five had the advanced directive signed by a family member and not the resident.	Ensure resuscitation forms are in place and completed by the resident that has been deemed competent. 90 days
Criterion	PA	Five care plans were reviewed for this	i) One hospital resident’s care plan did not document pain	Ensure that

1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.	Moderate	audit. All five had aspects of appropriate documentation, and all documented that the generic template had been reviewed and changed. One of five care plans reviewed (dementia) included all residents' documented needs. Improvements continue to be required around care plan interventions.	interventions (where pain was an issue), specific care for a urinary catheter, and action needed when the resident refused care (as they often did). This care plan had not been updated to reflect the resident's improved condition; ii) one hospital resident's care plan did not document care for an ostomy, resident positioning and the service expectations regarding this resident's use of non-prescribed medication; iii) one rest home resident's care plan did not reflect the trial foot care, and the resident's preference for sleeping in a chair; and iv) one dementia resident's care plan did not document interventions for challenging behaviour.	all residents' interventions and care requirements are documented in care plans. 60 days
Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Moderate	Five resident files were reviewed for this audit. All residents had a care plan in place. Care staff interviewed were able to describe the care and support needed. Wound assessment, wound management and evaluation forms/plans were in place for all wounds; one lesion (dementia), one chronic ulcer and two skin tears (hospital). There were two non-facility acquired pressure injuries (one person, hospital level). Shortfalls continue to be identified around wound management plans.	(i) One hospital level resident did not have turns documented as directed by the care plan. (ii) A review of wound care plans included the following; three wound care plans included more than one wound on the form (one dementia, two hospital). One pressure injury (hospital) and one lesion (dementia) were not documented as evaluated according to set timeframes, and one pressure injury was not graded and the interventions to treat the wound were not clear (hospital).	(i) Ensure turns are documented as directed (ii) Ensure all wound care plans have one wound per form and include clear direction. Ensure wound evaluations are documented according to set timeframes.

				90 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.