

# Birchleigh Management Limited - Birchleigh Residential Care Centre

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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:

<b>Legal entity:</b>	Birchleigh Management Limited
<b>Premises audited:</b>	Birchleigh Residential Care Centre
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 7 November 2017      End date: 8 November 2017
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	83



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

## General overview of the audit

Birchleigh Residential Care Centre is certified to provide rest home, dementia and hospital (medical and geriatric) level care for up to 83 residents. On the day of audit, there were 83 residents. The service is overseen by a chief executive officer who reports to a Board of Directors. Each unit is managed by an experienced nurse manager (registered nurse). Residents and families interviewed were complimentary of the service that they receive.

This surveillance audit was conducted against a subset of the Health and Disability Service Standards and the district health board contract. The audit process included a review of policies and procedures, the review of resident and staff files, observations and interviews with residents, family members, staff and management.

Three of five shortfalls identified at the previous audit have been addressed. These were around care planning timeframes, medication management and water temperatures. There continues to be an improvement required around adverse event reporting and wound documentation.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Communication with residents and families is appropriately managed and documented. The complaints process is provided to residents and families as part of the admission process. A complaints register is in place that includes all complaints, dates and actions taken. Complaints are being managed in an appropriate manner and meet the requirements set forth by the Health and Disability Commissioner.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Organisational performance is monitored through a number of processes to ensure it aligns with the identified values, scope and strategic direction. The business plan has goals documented. There are policies and procedures that support and guide staff providing care to residents with rest home, hospital and dementia level needs. There is a quality and risk management programme in place. Staff receive ongoing training and there is a 2017 training plan in place. Rosters and interviews indicate sufficient staff that allows flexibility of staffing around clients' needs.

## 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 low risk.
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Assessments, care plans and evaluations are completed by a registered nurse. Each resident has access to an individual and group activities programme. The group programme is varied and interesting. Medication is stored appropriately in line with legislation and guidelines. General practitioners review residents at least three monthly or more frequently if needed. Meals are prepared on-site by a contracted company. The menu is varied and appropriate. Individual and special dietary needs are catered for. Alternative options are provided. Residents and relatives interviewed were complimentary about the food service.

## 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 holds a current warrant of fitness. The rooms are large and suitable for hospital level care. All rooms have ensuites and are large enough to cater to hospital level residents and their required equipment and carers. The separate lounge and dining room in the current wing proposed to change to dual-purpose beds, are able to accommodate the equipment needs of hospital level care residents.

## 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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Birchleigh Residential Care Centre has restraint minimisation and safe practice policies and procedures in place. Staff receive training in restraint minimisation and challenging behaviour management. The service has achieved a restraint-free environment. Three hospital residents have bedrail 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.		Standards applicable to this service fully attained.
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The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events.

## 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>	0	14	0	2	0	0	0
<b>Criteria</b>	0	39	0	2	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>A complaints policy and procedure has been implemented and residents and their family/whānau are provided with information on admission. Each of the three units had the complaints policy posted in a visible area with complaints forms and advocacy information nearby. The residents and families interviewed from each of the three units were aware of the complaints process and to whom they should direct complaints. No complaints were made in 2016 and 2017 for both the Silverstream rest home unit and Janefield dementia unit. One complaint had been made in 2016 and two complaints received in 2017 year-to-date for the Braeside hospital unit. The three complaints reviewed demonstrated investigation, follow-up and responses to the complainant.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment</p>	FA	<p>Seven residents (one hospital and six rest home) interviewed, stated they were welcomed on entry and were given time and explanation about the services and procedures. There is an incident reporting policy, and reporting forms that guide staff around their responsibility to notify family of any resident accident/incident that occurs. Fifteen exception reports (incident/accidents) and corresponding residents' files were reviewed, and all identified that next of kin were contacted. Six relatives (four rest home and two dementia care) stated that they are informed when their family members health status changes. Regular resident and family meetings provide a forum for residents to discuss issues or concerns. An interpreter policy and contact details of interpreters are available. The information pack is available in large print and this can be read to residents.</p>

conducive to effective communication.		
<p><b>Standard 1.2.1: Governance</b></p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Birchleigh Residential Care Centre is part of Birchleigh Management Limited. Birchleigh Residential Care Centre provides residential services for up to 83 residents requiring rest home, hospital, (geriatric and medical) and dementia level care. At the time of the audit there were 83 residents. The service is divided into three units, Silverstream rest home unit, Braeside hospital unit and Janefield dementia level unit. There were 33 residents in the rest home unit, 26 residents in the hospital unit (25 hospital and one rest home), and 24 residents in the dementia care unit. All residents were under the age related residential care (ARRC) contract.</p> <p>Birchleigh Residential Care Centre is managed by the chief executive officer (CEO), a non-clinical person who has been in the role for ten years. The CEO reports to a board of directors. The CEO is supported by three experienced nurse managers and a domestic services manager. The nurse manager at Silverstream rest home unit has been in the role for 18 years, the nurse manager at Braeside hospital unit has been in the position for 6 years and the nurse manager at Janefield dementia level unit in the role since July 2017 and has been a nurse manager at another facility for over 10 years. The domestic services manager has been at the service for over 20 years.</p> <p>The goals and direction of the service are well documented in the business/quality and risk management plan and the progress toward previous goals has been documented through monthly reports to the boards, staff meetings and monthly staff communication leaflets. The CEO has maintained eight hours annually by attending regular professional development and industry conferences.</p>
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>Quality improvement processes are in place to capture and manage non-compliances. They include internal audits, hazard management, risk management, incident and accident, infection control data collection and complaints management. Quality improvement data is discussed at three monthly staff meetings in each unit and monthly at the senior management and quality meetings. Meeting minutes reviewed evidenced that there is good communication and feedback to staff and management around quality outcomes and KPIs. Each of the nurse managers' implement the quality programme in their own unit. The internal audit schedule is implemented in all three units. Corrective action plans are developed, implemented and signed off when service shortfalls are identified. Monthly trend analysis is posted in staff rooms and document infection control graphs and incident/accident graphs such as falls, skin tears and bruises.</p> <p>There are policies and procedures that are relevant to the various service types offered and are reviewed two yearly. There is a current risk management plan. Hazards are identified, managed and documented on the hazard register. Health and safety issues are discussed at staff meetings, quality meetings and reported monthly to the board. Action plans were documented to address issues raised. There are resident surveys conducted and analysed with corrective action plans developed when required. The annual resident satisfaction survey in November 2016 demonstrated a high level of satisfaction with the service. Any required corrective actions were</p>

		developed, followed up and signed off. Falls prevention strategies are in place for individual residents.
<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>	PA Low	<p>Policy and procedures guide staff around incident and accident reporting. The accident/incident process (exception reports) includes documentation of the incident and analysis and separation of resident and staff incidents and accidents. Five resident exception reports for September and October 2017 were reviewed for each of the three units. All the exception reports reviewed documented that clinical follow-up of residents is conducted by a RN, however, with four exception reports (three dementia and one rest home) reviewed for residents unwitnessed falls with a head knock/injury, there was no documented evidence of neurological observation forms being completed.</p> <p>Two hospital resident pressure injury incidents had exception reports fully completed including an RN assessment and follow-up. This previous shortfall has been addressed. Accidents and incidents are analysed monthly with results discussed at monthly quality improvement meetings and three-monthly staff meetings. The CEO and nurse managers were aware of situations that require statutory reporting. There have been no requirements to complete any section 31 notifications since the last audit.</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>Human resources policies include recruitment, selection, orientation and staff training and development. Nine staff files were reviewed, (one nurse manager and one caregiver for the dementia care unit, one nurse manager and two caregivers from the rest home, one nurse manager and two caregivers from the hospital and one activities coordinator). All documented appropriate employment practices and documented annual appraisals as needed and current job descriptions. Current annual practising certificates are kept on file. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme is developed specifically to worker type (eg, RN, support staff) and includes documented competencies.</p> <p>There is an annual education and training schedule being implemented for 2017 and a completed annual education and training schedule for 2016/17. There are competencies for RNs related to specialised procedure or treatment including (but not limited to), medication management, insulin administration, moving &amp; handling, nebuliser, oxygen administration, PEG tube care/feeds, restraint, wound management, syringe driver and medication competencies. Residents and families state that staff are knowledgeable and skilled. There are 20 caregivers who work in the dementia care unit and 16 have completed the required dementia standards. Four caregivers are in the process of completing their qualification and have commenced work within the last 12 months.</p>
Standard 1.2.8:	FA	There is a documented rationale for staffing the service. Staffing rosters were sighted, and staff are on duty to

<p>Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>match needs of different shifts and needs of different individual residents. The nurse managers are on-call after-hours for each unit. There is a RN and first aid trained member of staff on every shift. Staff interviewed advised that there are sufficient staff on duty at all times. Interviews with residents and relatives confirm that there are sufficient staff on duty. The service is divided into three units, the Silverstream 33-bed rest home unit, Braeside 26-bed hospital unit and Janefield 24-bed dementia care unit. Each unit has a full-time nurse manager who work 40 hours per week from Monday to Friday.</p> <p>There are 25 hospital level residents and one rest home resident living in the Braeside hospital unit. There is one RN is on duty on the morning and afternoon shifts, and one on the night shift. Four caregivers (all long shift) are on duty on the morning and four caregivers (three long and one short shift) are on duty on the afternoon shifts and one caregiver is on duty on the night shift. There are 33 Silverstream rest home residents living in the rest home unit. Four caregivers (two long and two short shift) are on duty on the morning and on the afternoon shifts, and one caregiver is on duty on the night shift. There are 24 Janefield dementia level residents living in the dementia care unit. Four caregivers (two long and two short shift) are on duty on the morning and three caregivers (two long and one short shift) on the afternoon shifts and two caregivers (long shift) are on duty on the night shift. (One of these caregivers can 'float' between Janefield and Silverstream, depending on resident needs).</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>The medication management policies and procedures comply with medication legislation and guidelines. Medicines are appropriately stored in accordance with relevant guidelines and legislation. Medication administration practice complies with the medication management policy for the medication rounds sighted. Medication prescribed is signed for correctly for the sample of medication charts reviewed in each area. The caregivers administer medicines in the rest home and dementia units. RNs administer medications to hospital residents. Staff who administer medication have been assessed as competent. The facility uses a blister pack medication management system for the packaging of all tablets. The RNs reconcile delivery, and this is documented. Medication charts are documented in an internet based electronic medication system by medical practitioners and there was evidence of three monthly reviews by the GP. All medications are prescribed and charted in line with guidelines. There were no residents self-administering medicines. Standing orders are in place in the hospital unit only and these are current. The previous partial attainment has been addressed.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids</p>	FA	<p>The food service at Birchleigh Residential Care Centre is provided by a contracted company. The kitchen is located at the adjacent retirement village and transported across to the facility in hot boxes. The meals are served to residents from small kitchens (one in each of the three units), which are located beside each dining room. Bain maries are used in each servery to ensure that food is served hot. The operations manager and the kitchen manager from an independent contracted food company oversee the food service. Food service manuals are in place to guide staff. A resident dietary profile is developed for each resident on admission and is provided to the</p>

<p>and nutritional needs are met where this service is a component of service delivery.</p>		<p>kitchen staff.</p> <p>The kitchen is able to meet the needs of residents who need special diets and the cooks work closely with the RNs. Kitchen staff have completed food safety training. The cooks follow a rotating menu, which has been reviewed by a dietitian. The temperatures of refrigerators, freezers and cooked foods are routinely monitored and recorded. There is special equipment available for residents if required. A cleaning schedule is maintained. Residents and the family members interviewed were very happy with the quality and variety of food served. The dementia unit is supplied with extra nutritious snacks for residents.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Low</p>	<p>Caregivers follow the care plan and report progress against the care plan each shift. If external nursing or allied health advice is required the RNs will initiate a referral (eg, to the district nurse). If external medical advice is required, this will be actioned by the GP. Staff have access to sufficient medical supplies (eg, dressings). Sufficient continence products are available and resident files include a continence assessment and plan. Specialist continence advice is available as needed and this could be described. Monitoring forms sighted were in place for enabler use, behaviour management, fluid balance charts, turning charts and pain management. Wound documentation is available and includes assessments, management plans, progress and evaluations.</p> <p>In the rest home there were ten residents with twelve wounds including two pressure injuries. Eight skin tears, one cellulitis and one ulcer. There was one ulcer in the dementia unit. In the hospital there was wound documentation in use for six residents with eleven wounds. One resident has two skin tears; a pressure injury and a skin lesion, one resident two skin lesions; two residents have one pressure injury each, one resident has an ulcer and two residents have one skin tear each. The RNs have access to specialist nursing wound care management advice through the district nursing service. Not all wound information (including pressure injury grading) was adequately documented. The previous partial attainment continues to require improvement.</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</p>	<p>FA</p>	<p>Two activities staff members facilitate the activities programme for all residents. One long-serving staff member is a trained teacher and the other is a RN. Each resident has an individual activities assessment on admission and from this information, an individual activities plan has been developed by the activities staff for five of the resident files sampled. The two staff members divide their time between the three units.</p> <p>Each unit has a separate programme and reflects the resident's cognitive and physical abilities. Activities in the dementia unit are provided for each morning and afternoon and include weekend activities. Caregivers are also involved in the programme in the dementia unit. Each resident is free to choose whether they wish to participate in the group activities programme or their individual plan. Participation is monitored. Group activities reflect ordinary patterns of life and include planned visits to the community. Residents and families interviewed commented positively on the activity programme.</p>

service.		
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>All initial care plans are evaluated by the RNs within three weeks of admission. The long-term care plan is reviewed at least six monthly or earlier if there is a change in health status. Reviews document progress toward goals (link 1.3.7.1). There is at least a three-monthly review by the GP. Changes in health status are documented and followed up. Care plan reviews are signed by an RN. Short-term care plans are evaluated and resolved or added to the long-term care plan if the problem is ongoing as sighted in resident files sampled. Where progress is different from expected, the service responds by initiating changes to the care plan.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>There are established systems in place to ensure the physical environment and facilities are safe and fit for their purpose. The facility has a current building warrant of fitness which expires on March 2018.</p> <p>Water temperatures are monitored, and corrective actions implemented if required. The previous partial attainment has been addressed.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Infection surveillance is an integral part of the infection control programme and is described in Birchleigh infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed, which includes signs and symptoms of infection, treatment, follow-up, review and resolution. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at staff meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the nurse managers. Since the previous audit a respiratory outbreak was appropriately managed.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate</p>	FA	<p>There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. The policy includes restraint procedures and identifies that restraint is used as a last resort. There was one dementia resident using a restraint (chair table) and four hospital residents with five enablers (four bed rails and one lap belt) on the day of audit. Two resident files reviewed demonstrated that enabler use is voluntary. The nurse manager (Braeside hospital) is the restraint coordinator. The use of enablers/restraint is discussed at clinical</p>

that the use of restraint is actively minimised.		meetings and quality/management meetings. Challenging behaviour and restraint minimisation and safe practice education has been provided.
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## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	PA Low	<p>Policy and procedures guide staff around incident and accident reporting. Two hospital resident pressure injury incidents had exception reports fully completed including an RN assessment and follow-up. This previous shortfall has been addressed. All the exception reports reviewed documented that clinical follow-up of residents is conducted by a RN, however, with four exception reports (three dementia and one rest home) reviewed for residents unwitnessed falls with a head knock/injury, there was no documented evidence of neurological observation forms being completed</p>	<p>Fifteen resident exception reports were reviewed in total for the three units. For four exception reports (three dementia and one rest home) reviewed for residents unwitnessed falls with a head knock/injury, there was no documented evidence of neurological observation forms being completed.</p>	<p>Ensure that any unwitnessed falls with a head knock/injury have neurological observation forms completed.</p> <p>90 days</p>

<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Low</p>	<p>Wound documentation reviewed included wound assessments, wound care plans and progress notes. The progress notes record the current wound dressings and how well the wound is healing. The service photographs wounds if required, to monitor progress. Wound and skin specialist input was also evidenced as having been accessed when required. Wound assessments and evaluations were not always fully documented. The facility amended the wound management form on the day of audit to include pressure injury grading.</p>	<p>i) Assessments of wounds have not been consistently documented at each dressing change for 20 of 24 files</p> <p>ii) Evaluations of wounds/dressing changes had not been consistently documented for four of 24 wounds</p>	<p>Ensure that wounds assessments and evaluations are documented for all wounds.</p> <p>90 days</p>
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## Specific results for criterion where a continuous improvement has been recorded

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

No data to display
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End of the report.