# Radius Residential Care Limited - Radius Baycare Home & Hospital

## 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Radius Residential Care Limited

**Premises audited:** Radius Baycare Home and Hospital

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

**Dates of audit:** Start date: 16 May 2018 End date: 17 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:** 45

# 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 |
|  | 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

Radius Baycare is part of the Radius Residential Care group. The service provides rest home, hospital level (medical services and geriatric services) care for up to 46 residents. On the day of the audit there were 45 residents.

This 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 the review of policies and procedures, the review of residents and staff files, observations and interviews with residents, family, management and staff.

The facility manager has been in the role since 2011 and has previous experience in aged care management. She is supported by a clinical manager and the Radius regional manager. Residents and family interviewed spoke positively about the service provided.

One of two shortfalls identified at the previous audit have been addressed, this was around interRAI assessments. Documentation of care plan interventions is a continued finding. This audit has identified two areas requiring improvement around medication management and care monitoring.

## Consumer rights

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| 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. |

Discussions with families identified that they are fully informed of changes in health status. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service.

## Organisational management

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| 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. |

A facility manager and clinical manager are responsible for the day-to-day operations. There is an implemented quality and risk management programme in place. Meetings are held to discuss quality and risk management processes. Residents meetings are held regularly, and residents and families are surveyed annually.

Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported.

There is an education and training programme in place. Comprehensive employment processes are adhered to. An orientation programme is in place for new staff. A roster provides sufficient staff for the effective delivery of care. Residents and families report that staffing levels are adequate to meet the needs of the residents.

## Continuum of service delivery

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| 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. |

Initial assessments and risk assessment tools are completed by the registered nurses or enrolled nurses on admission. Registered nurses and enrolled nurses are responsible for care plan development with input from residents and family. Planned activities are appropriate to the residents’ assessed needs and abilities and residents advised satisfaction with the activities programme. There are medication policies and procedures in line with legislation and current regulations. Food, fluid and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

## Safe and appropriate environment

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| 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

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| 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 a philosophy to minimise the use of restraint and employs a variety of techniques to achieve this. At the time of the audit, there were two residents with restraint and five with enablers. Enabler use is voluntary.

## Infection prevention and control

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| 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. |

There is an implemented infection control programme that complies with current best practice. Infection control surveillance is established that is appropriate to the size and type of services. There is a defined surveillance programme with monthly reporting by the infection control coordinator.

## Summary of attainment

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

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| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 14 | 0 | 1 | 2 | 0 | 0 |
| **Criteria** | 0 | 40 | 0 | 1 | 2 | 0 | 0 |

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| **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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

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| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | Radius Baycare has a complaints policy and procedure in place. The complaints procedure is provided to residents and their family within the information pack at entry. Complaints forms are available at reception.  Six complaints were made in 2017 and two complaints have been received in 2018 year to date. All complaints are now logged on to the electronic database. A review of the electronic complaints register evidences that appropriate and timely actions have been taken in the management and processing of these complaints.  Meeting minutes document discussion of complaints. Residents and families stated that the manager is very proactive and addresses issues raised very quickly. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | There is a policy to guide staff on the process around open disclosure. The facility manager and clinical manager confirmed that family are kept informed. Relatives (two hospital and two rest home) stated they are notified promptly of any incidents/accidents. Residents/relatives have the opportunity to feedback on service delivery through annual surveys and open-door communication with management. Monthly resident meetings encourage open discussion around the services provided (meeting minutes sighted). Accident/incident forms reviewed evidenced relatives are informed of any incidents/accidents.  Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The facility has an interpreter policy to guide staff in accessing interpreter services. Residents (and their family/whānau) are provided with this information at the point of entry. Families are encouraged to visit. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Radius Baycare is part of the Radius Residential Care group. The service provides rest home, hospital level (medical services and geriatric services) care for up to 46 residents. On the day of the audit there were 45 residents (20 rest home including 1 under the long-term chronic conditions contract, and 25 hospital level residents, including 1 younger person disabled). All 45 beds are dual-purpose.  The service has a business plan 2017 – 2018. The plan includes both business and quality objectives. The service reports against the business and quality objectives to the regional manager.  The facility manager is very experienced and has been in the role since 2011. She is supported by an experienced clinical nurse manager, who has been in the role at Baycare for one and a half years. The regional manager also supports the facility manager in the management role and was present during the second day of the audit. The facility manager has maintained more than eight hours of professional development activities related to managing an aged care 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 quality improvement principles. | FA | An established quality and risk management system is embedded into practice. Quality and risk performance is reported across facility meetings and to the regional manager. Discussions with the managers and staff (one registered nurse, one enrolled nurse, three healthcare assistants, the cook and an activity coordinator) reflects their involvement in quality and risk management processes. Facility meetings include: monthly staff meetings, one to two monthly quality meetings, quarterly health and safety meetings, monthly senior staff meetings and monthly resident meetings. Meeting minutes reviewed document that quality outcomes are communicated to all staff. Annual resident and relative surveys are completed with results communicated to residents and staff.  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, including those standards relating to the Health and Disability Services (Safety) Act 2001.  Health and safety policies are implemented and monitored by the Health and Safety Committee. The health and safety representative interviewed, confirmed her understanding of health and safety processes including recent law changes.  The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Radius has achieved tertiary level ACC Workplace Safety Management Practice.  Falls prevention strategies are in place including intentional rounding, sensor mats, post falls reviews and individual interventions. |
| 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 | There is an incident/accident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring, corrective action to minimise and debriefing. There is a discussion of incidents/accidents at staff and quality meetings including actions to minimise recurrence.  Fifteen incident forms were logged for April on the electronic system. A review of the electronic log, including five in-depth incident forms reviewed, identified that forms are fully completed and include follow up by a registered nurse (RN). Neurological observations are carried out for any suspected injury to the head. All incidents reviewed had documented analysis to identify opportunities to improve service delivery and manage risk. Discussions with the facility manager confirms that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications with examples of situations provided. No Section 31 forms have been completed in the last year and one completed for a non-facility acquired pressure injury in 2016. |
| 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 | Human resources policies include recruitment, selection, orientation and staff training and development. Five staff files reviewed (two RNs and three healthcare assistants), include a comprehensive recruitment process, which includes: reference checking, signed employment contracts, job descriptions, police checks, completed orientation programmes and annual performance appraisals. A register of RN and other health practitioner practising certificates is maintained. The orientation programme provides new staff with relevant information for safe work practice. Staff are required to complete written core competencies during their induction. These competencies are repeated annually.  There is an implemented annual education and training plan that exceeds eight hours annually. Education for the electronic care planning system has been provided and followed through in RN meetings. There is an attendance register for each training session and an individual staff member record of training. Four of five RNs have completed their interRAI training with one in the process, this is an improvement from the previous audit. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | A policy is in place for determining staffing levels and skills mix for safe service delivery. There is a full-time facility manager (RN) who works Monday to Friday and provides on call. The clinical nurse manager works three days a week with support from an enrolled nurse. An RN works on the other four-day shifts. There is a registered nurse roster 24/7.  HCA staffing  Hospital (25 Hospital): There are four long shifts and one short shift for the AM, one long and three short shifts (staggered over the shift to ensure there are always two staff) for the PM and one HCA on nights  Rest home (20 rest home): There are two long shifts for the AM, one long shift for the PM and one HCA on nights.  Residents and family members interviewed report there are sufficient staff numbers. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate | Medications are checked against the doctor's medication profile on arrival from the pharmacy by a registered nurse. Any mistakes by the pharmacy are regarded as an incident. Medications are stored safely in the treatment room and no expired medications are on-site.  Designated staff are listed on the medication competency register which shows signatures/initials to identify the administering staff member. A registered nurse was observed safely and correctly administrating medications.  Resident medication charts are identified with demographic details and photographs. The medications fridge is monitored daily. All ten medication charts sampled had allergies (or nil known) and indications for use for ‘as required’ medications documented. All medications had been reviewed by a GP at least three-monthly, where the resident had been at the service for longer than three months.  There were no residents who self-administered medications. The medication charting for short-term medications had no stop date, the process for controlled medications was not according to policy and not all medication was signed for when administered. |
| 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 | The service has a large workable kitchen. The kitchen and the equipment are well maintained. The service employs sufficient kitchen staff to provide meal services over seven days a week. There are rotating four-weekly menus in place that are designed by a dietitian. Diets are modified as required. There is a choice of foods and the kitchen can cater to specific requests if needed. There was evidence that likes and dislikes are catered for, including last minute requests.  Food safety information and a kitchen manual are available in the kitchen. The food safety plan was approved and expires Dec 2018. Food served on the day of audit was hot and well presented.  The residents interviewed spoke positively about meals provided and they all stated that they are asked by staff about their food preferences and that these were met. Alternatives are provided when a resident does not like the meal provided.  The service has a process of regular checking of food in both the fridge and freezers to ensure it is disposed of when use by date expires. All food is stored and handled safely. Food temperatures are recorded. The kitchen is clean.  Kitchen 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 is in the process of fully implementing a computerised care planning system. All residents have a copy of a paper-based care plan which is kept at the nurse’s station and each resident plan is being transferred over to the computer system. The service has a dual system until the computerised care plan is fully implemented. However, not all care plans included interventions to support all current assessed needs (either documented on the paper-based care plan or the computer-based system). This continues to be an improvement required since the previous audit. The service has recognised this shortfall also and an action plan is in place which includes additional training. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Low | In files reviewed, the use of short-term care plans was evident. Observation of care and interviews with staff and resident’s evidences that the residents are receiving care that meets all their needs, however this is not always documented. The resident on a YPD contract has a current needs assessment. The care plan for the YPD was resident focused and goal orientated.  Continence products are available and resident files include a 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 a physiotherapist visits the facility for a minimum of two hours weekly. A contracted dietitian is available and provides input when this is required.  Dressing supplies are available, and a treatment room is stocked for use. Wound assessment and wound management plans were in place for six wounds, including one stage II pressure injury. However, not all wound plans were fully documented. There is evidence in files of the wound specialist referrals. Wound care is completed within timeframes.  Monitoring charts are in use; however, shortfalls were identified around pain assessment/monitoring and restraint monitoring |
| 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 | An activities coordinator is employed 30 hours per week to coordinate and implement an activities programme Monday to Friday 8.30am to 3.00pm for all residents. Each resident is free to choose whether they wish to participate in the group activities programme or their individual plan. Participation is monitored.  On the day of audit, residents were observed being actively involved with a variety of activities. Residents have a comprehensive assessment completed over the first few weeks after admission, obtaining a complete history of past and present interests, career and family.  Activities are age appropriate and have been comprehensively planned. Activities provided are meaningful and reflect ordinary patterns of life.  Five long-term resident files reviewed identified that the individual activity plan is reviewed at the time of the care plan review.  The service has continued to maintain an integrated activity programme that is developed with the residents. Family, residents and staff reported that the activity programme is highly appreciated. The kapa haka group, golf and photo diaries have continued. Monthly resident meetings document a high level of resident interaction and the activity programme is changed and added to, depending on resident feedback. The resident survey for 2018 had documented an increase on satisfaction for activities from 50% in 2017 to 78% very satisfied in 2018 |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | All care plans sampled have been evaluated by the registered nurses within three weeks of admission. The long-term care plans sampled have been evaluated using interRAI at least six-monthly or earlier, if there is a change in health status (link 1.3.5.2). There is at least a three-monthly review by the GP. Care plan reviews are signed by a registered nurse. Short-term care plans are documented for acute changes in condition and evaluated. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness is posted in a visible location. Reactive and preventative maintenance occurs. |
| 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 surveillance of infection data assists in evaluating compliance with infection control practices. Infections are collated monthly - including urinary tract, upper respiratory, skin and infections that do not require antibiotics. This data is analysed and acted upon and reported to the facility meetings. Monthly data was seen in staff areas. The service submits data monthly to Radius head office where benchmarking is completed. There have been no outbreaks since the previous audit. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | There is a restraint minimisation and safe practice policy that is applicable to the service and has recently been updated by the organisation. The aim of the policy and protocol is to minimise the use of restraint and any associated risks. There are two residents using restraint and five residents using enablers. All enablers have a consent signed by either the resident or the activated EPOA. The service is currently in the process of transferring the restraint process from paper-based system and log to the electronic system (link to 1.3.5.2 and 1.3.6.1). The manager and restraint coordinator were able to explain the process for restraint and enabler use. |

# 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.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.3.12.1  A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | All medications are kept in the treatment room. Staff who administer medication complete an annual competency assessment and the registered nurse observed administering medication, followed correct protocol. However, not all prescribed medications were signed as administered, not all short-term medications were correctly prescribed and the process for controlled medications was not followed according to policy. | (i)When administering controlled medications for a shift with only one RN, the service checks out the medication and puts the medication in a pot. The register is signed by one RN at this point. The administering staff member documents the second signature later. The administration records for controlled medications have only one signature. (ii) Three of ten medication charts reviewed included medications that had been discontinued. These medications had not been discontinued on the medication chart and had no stop date. (iii) One medication chart had a regular medication not signed for. | (i)Ensure that controlled medication is checked out of the secure cupboard according to policy and two members of staff sign when administered. (ii) Ensure that medications that are discontinued and/or short-term medications have a stop date. (iii) Ensure that medications are signed for when administered.  60 days |
| Criterion 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. | PA Moderate | Each resident has a care plan documented. Of the care plans reviewed, one was paper based and the other four have been updated onto the electronic system. However, not all care plan interventions fully reflected the resident’s assessed needs. | (i)The interRAI was up to date for one rest home residents, but care plan interventions have not been updated to reflect the interRAI.  (ii)One rest home resident has no interventions to reflect the resident’s risks around smoking (bringing lit cigarettes back into the room where there is oxygen).  (iii) One hospital level resident’s care plan had not been updated to include comfort cares and the need for regular, strong analgesia.  (iv) One hospital resident’s care plan does not include management of confusion and behaviours that challenge.  (v) One resident with restraint does not have this documented in the care plan. | Ensure that care plans document interventions that reflect current resident assessed needs.  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 Low | The service is in the process of fully implementing an electronic care planning system. Observation of the residents and discussion with staff evidences that resident care is undertaken to ensure a safe and supportive environment. Staff interviewed were knowledgeable regarding resident needs. Families and resident interviewed stated that the care was very good. The care plans do not reflect that all resident interventions are taking place. The service has recognised this gap and an action plan is in place which includes additional training. Monitoring charts are in use; however, shortfalls were identified around pain assessment/monitoring and restraint monitoring | (i)Pain monitoring was not documented for two hospital residents with identified pain.  (ii) Restraint monitoring has not been documented for one resident with restraint.  (iii) Of the three wound care plans reviewed, the documentation did not include a fully completed wound assessment and management plan. | (i)-(ii) Ensure that pain and restraint monitoring is documented. (iii) Ensue that wound assessment and care plans are fully documented  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.

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| No data to display |

End of the report.