Little Sisters of The Poor Aged Care New Zealand Limited - Sacred Heart Home and 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.

The specifics of this audit included:

Legal entity:	Little Sisters of The Poor Aged Care New Zealand Limited
Premises audited:	Sacred Heart Home & Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 22 February 2018 End date: 22 February 2018

Proposed changes to current services (if any): The service has reconfigured the certified services by converting 17 rest home beds to dual-purpose. The dual-purpose beds have increased to a total of 24 beds. One room (Room 29) remains as rest home only. The total beds have remained unchanged. The 17 rest home rooms were verified at this audit as suitable for dual-purpose.

Total beds occupied across all premises included in the audit on the first day of the audit: 52

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

Sacred Heart Home and Hospital provides hospital (geriatric) and rest home level care. The board undertakes a mission 'to provide health care services for the elderly, all cultures and all religions. The service provides rest home and hospital level of care for up to 53 residents, with 52 residents on the day of audit.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the district health board. This audit process included the review of policies and procedures, the review of residents' and staff files, observations, and interviews with residents, management and staff.

Sacred Heart Home and Hospital is managed by a Mother Superior and another sister, who is in the role of clinical manager. Both receive support from the sisters living at Sacred Heart, administration staff, registered nurses and care staff. The residents and relatives interviewed all spoke positively about the care and support provided.

Two of the three shortfalls identified at the previous audit have been addressed. These were around medication storage and a communal shower. Further improvement continues to be required around wound management.

This surveillance audit identified an additional improvement required around interRAI timeframes.

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.

Communication with residents and families is appropriately managed. Complaints are actioned and include documented response to complainants. A complaints register is maintained.

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.

Sacred Heart is implementing a quality and risk management system that supports the provision of clinical care. Quality and risk data is collated for residents' falls, infection rates, complaints received, restraint use, pressure injuries and medication errors. Corrective actions are developed and implemented. Complaints processes are implemented and managed according to the code. The service has a culture of health and safety. There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. There is an education programme covering relevant aspects of care and external training is supported. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

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.

The registered nurses are responsible for each stage of service provision. The assessments and care plans are developed in consultation with the resident/family/whānau. The activity programme is varied and appropriate to the level of abilities of the residents. Medications are appropriately managed, stored, and administered with supporting documentation. Medication training and competencies are completed by all staff responsible for administering medicines. Food is prepared on-site with individual food preferences, dislikes and dietary requirements assessed by the registered nurses.

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 service displays a current building 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.

Restraint policy and procedures are in place. The definitions of restraints and enablers are congruent with the definitions in the restraint minimisation standard. Staff regularly receive education and training on restraint minimisation and managing challenging behaviours. There were twelve residents voluntarily using enablers and two residents with restraints.

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 (registered nurse) is responsible for coordinating education and training for staff. The infection control coordinator uses the information obtained through surveillance to assist in determining infection control activities and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections.

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	15	0	2	0	0	0
Criteria	0	40	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)
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 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	There is a complaints policy to guide practice, which aligns with Right 10 of the Code. The facility manager (Mother Superior) leads the investigation of any concerns/complaints. Sacred Heart has a complaints procedure which is provided to residents within the information pack at entry. Seven complaints from 2017 were reviewed and reflected evidence of responding to the complaints in a timely manner with appropriate follow-up actions taken. There have been no complaints to date for 2018. Documentation including follow-up letters and resolution demonstrates that complaints are being managed in accordance with guidelines set forth by the Health and Disability Commission. There is a suggestions/complaints box. Discussions with residents and families confirmed they were provided with information on complaints during their entry to the service. Complaints forms, and a suggestions box are located in a visible location at the entrance to the facility.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an	FA	There is a policy to guide staff on the process around open disclosure. The facility manager (Mother Superior), clinical nurse manager (CNM) or registered nurse (RN) welcomes residents and families on entry and explain about services and procedures. All ten incident forms reviewed for January and February 2018, identify family were notified following a resident incident/accident. The RNs confirm family are kept informed. The relatives interviewed confirmed they are notified promptly of any incidents/accidents. Six residents (four rest home and two hospital) interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. Family members (one

environment conducive to effective communication.		hospital, one rest home) advised that they are encouraged to discuss any concerns with the facility manager and/or registered nurse.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Sacred Heart is certified to provide hospital (geriatric and medical) and rest home level care for up to 53 residents. There is a 28-bed dedicated hospital wing, and a 25- bed rest home wing. As part of this audit, 17 of the rest home rooms were verified as suitable to be used as dual -purpose. The dual-purpose beds have increased to a total of 24 beds (one rest home bed and 24 dual-purpose beds). At the time of this audit, there were 52 residents including 28 hospital level care residents and 24 rest home level care residents. All residents were under the aged related contract. There were no respite residents. The facility is governed by a mission board located in Auckland. Sacred Heart concentrates on providing care to the residents in a holistic and focused way. The business plan goals for 2017 have been reviewed and evaluated. A business, quality and risk management plan describes the five key goals of the facility (consumer focus, provision of effective programmes, certification and contractual requirements, risk management and continuous improvements). Each goal describes the objectives, management controls, measurements and allocated responsibility. Goals are monitored annually by the quality improvement team. The Mother Superior oversees the running of the facility with clinical management delegated to a nurse manager. The nurse manager has been in the role for the past three years and is a registered nurse with extensive experience in aged care management. Regular visits from the trust board members, monthly reports and six-monthly board meetings ensure that there is good communication between the mission board and local governance. The facility manager and clinical nurse manager have maintained over eight hours annually of professional development activities related to managing an aged care service.
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	FA	Sacred Heart is implementing a quality and risk management system. The Mother Superior and a designated Sister (quality coordinator) oversee the quality programme. The quality programme includes goals for 2018. The 2017 plan has been reviewed. Quality and risk management systems are implemented with a number of quality initiatives that reflect evidence of evaluation and positive outcomes for residents and/or staff. Interviews with the manager, clinical nurse manager and staff (three caregivers, three registered nurses, one activities coordinator, one cook and two kitchenhands) reflect their understanding of the quality and risk management systems that have been put into place. The service collates accident/incident and infection control data. Meeting minutes, monthly data comparisons, trends and graphs are available for staff information. The caregivers interviewed were aware of quality data results, trends and corrective actions. An internal audit programme covers all aspects of the service. The outcomes of internal audits are discussed with staff at the various meetings. Corrective actions have been developed and implemented for shortfalls in service areas. A corrective action plan, following a complaint in 2017 was implemented and closed out.

principles.		A resident and relative survey was conducted in April 2017. Results have been collated, analysed and reported back to residents or family. Outcomes from the survey evidence a high level of satisfaction. Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are regularly reviewed. New policies or changes to policy are communicated to staff. There is an implemented health and safety and risk management system in place including policies to guide practice. There are designated health and safety staff representatives. Hazard identification forms and a hazard register are in place. A health and safety orientation programme is in place for staff. Staff confirm they are kept informed on health and safety matters at meetings. Fall prevention strategies are in place that include the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls
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	A sample of ten accident/incident forms for January and February were reviewed. There has been RN notification and clinical assessments completed within a timely manner. Accidents/incidents were recorded in the resident progress notes. There is documented evidence the family/whānau had been notified promptly of accidents/incidents. Pressure injuries (current and previous) have been reported. The service collects incident and accident data and reports the data to the quality meetings, the health and safety meeting and the staff meetings. Staff interviewed confirm incident and accident data are discussed at the various meetings and information and graphs have been made available.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in	FA	There are human resources policies to support recruitment practices. Six staff files (two care workers, two RNs, one activity coordinator and one clinical nurse manager) sampled, contained all relevant employment documentation. Current practising certificates were sighted for the RNs, and allied health professionals. Performance appraisals were up-to-date. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed believed new staff were adequately orientated to the service on employment. The education planner in place covers the compulsory education requirements as well as additional clinical in-

accordance with good employment practice and meet the requirements of legislation.		service and external education. Nine of the twelve RNs have completed interRAI training. The service has an on-site aged care training programme available for all staff. Staff complete competencies relevant to their role including medication, observations and safe manual handling.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. A roster provides sufficient and appropriate coverage for the effective delivery of care and support. The morning shift in the hospital (28 occupied beds) is covered by two registered nurses and five care workers and the afternoon shift has one RN and four care workers. The rest home (24 occupied beds) morning and afternoon shifts include an RN and three care workers on each shift. The Mother Superior, the clinical manager and the other Sisters are on-site full time and available after hours. Night shift is covered by one RN and two care workers. A diversional therapist is rostered Monday to Friday. She is supported by an activities coordinator who commences work mid-afternoon (four hours) on Monday to Friday. Staff reported that staffing levels and the skill mix were appropriate and safe. Residents interviewed advised that they felt there is sufficient staffing.
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.	FA	There are policies and procedures in place for safe medicine management that meet legislative requirements. All clinical staff who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided. Registered nurses and care staff interviewed were able to describe their role in regard to medicine administration. All medications are managed appropriately in line with required guidelines and legislation. Twelve medication charts sampled met all the prescribing requirements. Residents who wish to self-medicate are appropriately assessed and supported to do so. Self-medicating competencies are reviewed three monthly and provided with a locking bedside cabinet to store medications. Residents are checked daily to ensure medications are taken. Previous shortfalls around self-medicating has been addressed. Internal medication audits are conducted six monthly. The medication charts reviewed identified that the GP had seen and reviewed the resident three monthly.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids	FA	All meals at Sacred Heart home and hospital are prepared and cooked on-site. There are four weekly summer and winter menus, which have been reviewed by a dietitian. Meals are prepared in a well-appointed kitchen adjacent to the rest home dining room for serving. There is adequate space in the rest home dining room to support the increase in dual-purpose beds. Food is transported to the hospital residents in hot boxes and served immediately to residents. Kitchen staff are trained in safe food handling and food safety procedures are adhered to. There is food available for residents outside of meal times. Residents who require special eating aids are provided for, to promote

and nutritional needs are met where this service is a component of service delivery.		independence. Resident dietary profiles and likes and dislikes are known to food services staff and any changes are communicated to the kitchen via the registered nurse or nurse manager. A dietitian visits the service as required. Supplements are provided to residents with identified weight loss issues. Weights are monitored monthly or more frequently if required. Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Interviews with residents and family members indicate satisfaction with the food service.
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	A written record of each resident's progress is documented. Changes are followed-up by a registered nurse. When a resident's condition alters, the registered nurse initiates a review and if required, a GP consultation or referral to the appropriate health professional is actioned. The clinical staff interviewed advised that they have all the equipment referred to in care plans necessary to provide care. Dressing supplies are available and treatment rooms are well stocked for use. Wound documentation was reviewed and includes wound assessment, treatment plans and evaluations and progress notes. Dressings were completed as per timeframes and assessments fully completed. This is an improvement on previous audit; however, pressure injury staging is not documented and therefore further improvements are required around wound care documentation. Wound care nurse specialist advice is readily available. Continence products are available and specialist continence advice is available as needed. Short-term care plans are recorded, reviewed and resolved or carried over to the long-term care plan. A physiotherapist and physiotherapist assistant are employed to assess and assist resident's mobility and transfer needs. Monitoring charts are utilised such as (but not limited to) turning charts, weight, behaviour, and food/fluid.
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 diversional therapist and activities assistant provide an activities programme over five days per week. Group activities are voluntary and developed by the activities staff. Residents are able to participate in a range of activities that are appropriate to their cognitive and physical capabilities. Sacred Heart home and hospital has its own van, which is used for resident outings. The group activity plans are displayed on noticeboards around the facility. In all files reviewed, there is evidence of one-on-one activities for those residents who do not participate in group activities. All interactions observed on the day of the audit indicated a friendly relationship between residents and activity staff. The resident files reviewed included a section of the lifestyle care plan was for activity and is reviewed six monthly. Residents interviewed spoke very positively of the activity programme with feedback and suggestions for activities made via meetings and surveys.
Standard 1.3.8: Evaluation	FA	Initial care plans are evaluated within three weeks of admission. Long-term care plans are reviewed and evaluated by the registered nurses or when changes to care occur, as sighted in the files reviewed. A multi-disciplinary team meeting is conducted annually for each resident and involves all relevant personnel. The house GP examines the

Consumers' service delivery plans are evaluated in a comprehensive and timely manner.		residents and reviews medication three monthly. Short-term care plans focus on acute and short-term needs, ongoing problems have been recorded in long-term care plans. Progress notes were comprehensive and documented follow-up of incidents or changes in resident condition.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The service displays a current building warrant of fitness, which expires on 4 March 2018. The maintenance person/health and safety leader oversees the maintenance programme. Scheduled maintenance is carried out and staff record issues that require attention. Hot water temperature checks are conducted and is provided between 40 and 45 degrees Celsius in resident areas. Medical equipment including scales and hoists have been checked and calibrated annually. Electrical equipment has been tested. There is sufficient equipment for the potential increase in hospital residents. There is a small internal seating area at the entrance available for residents and visitors. Residents were observed safely mobilising throughout the facility. There is easy access to the outdoors. The exterior and gardens are well maintained with safe paving, outdoor shaded seating, lawn, gardens and car parking. Interviews with the registered nurses and the caregivers confirmed that there was adequate equipment to carry out the cares according to the residents' care plans. The service has reconfigured the certified services by converting 17 rest home beds to dual-purpose. The dual-purpose beds have increased to a total of 24 beds. One room (Room 29) remains as rest home only. The total beds have remained unchanged. The 17 rest home rooms were verified at this audit as suitable for dual-purpose. Rooms were spacious and allowed for the use of mobility equipment.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance	FA	Resident rooms are all single rooms with full ensuites in the hospital area and toilet and hand basin in the dual-purpose and rest home area. The number of resident communal toilets and showers provided in the rest home is adequate. Hand washing and drying facilities are located adjacent to the toilets. Liquid soap and paper towels are available in all toilets. Fixtures, fittings and floor and wall surfaces in the hospital area are made of accepted materials to support good hygiene and infection prevention and control practices. The communal toilets and showers are well signed and identifiable and include vacant/engaged and in-use signs. All communal showers in the rest home area meet infection prevention standards. This previous partial attainment has been addressed. Communal bathrooms in the rest home area allow for the use of mobility equipment.

with personal hygiene requirements.		
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	There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information obtained through surveillance to determine infection control activities and education needs in the facility. Infection control data and relevant information is displayed for staff. Definitions of infections are in place appropriate to the complexity of service provided. Infection control data is discussed at facility meetings. Annual infection control reports are provided. Internal audits for infection control are included in the annual audit schedule. There is close liaison with the GP that advises and provides feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility. There have been no outbreaks.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. The policy includes comprehensive restraint procedures. Interviews with the staff confirm their understanding of restraints and enablers. Enablers are assessed as required for maintaining safety and independence and are used voluntarily by the residents. On the day of audit, the service had two residents using restraint in the hospital unit, one with bedrails and a lap belt and one just with bedrails. There were 12 hospital residents documented using bedrails as an enabler. All enabler use is voluntary. A sample of files reviewed evidenced completed enabler monitoring forms. The restraint/enabler assessment form was completed, with input from the RN, GP and the resident's family and this was documented in the files of residents who were using bedrails. Two residents using bedrails as enablers were interviewed and confirmed the use is voluntary. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. The restraint standards are being implemented and implementation is reviewed through internal audits and facility meetings. There was a restraint/enabler annual review completed for the enabler use in 2017.

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 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the	PA Low	Six resident files (four hospital and two rest home) reviewed evidence that an initial assessment and initial care plan were developed for each resident within 24 hours of admission. Long-term care plans have been commenced and evaluated at six-month intervals. Long-term care plans are based on the interRAI assessment and contain triggers identified in the interRAI assessment, however, not all resident files evidence that interRAI reviews have been completed within six months.	Three of six files (two hospital and one rest home) did not have interRAI assessment reviewed within the six-month timeframe.	Ensure that all interRAI assessments are reviewed within the six-month timeframe. 90 days

needs of the consumer.				
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	All the wound care charts sighted in both rest home and hospital wings have completed wound assessments, plans and are regularly evaluated. All dressing changes occur as planned frequency. Wound plans contain instruction on type of dressing required, and instruction for caregivers responsible for dressing changes in the rest home area. Wound care specialist is involved with the resolving pressure injury. The GP reviews residents more frequently when they have a wound. Photos are obtained of wounds regularly, to show progression or deterioration; however, pressure injuries are not staged on the wound assessment form. Wound evaluations are comprehensive and document measurements to indicate progression of the wound. On the day of the audit two charts were in place for pressure injuries, one long-term pressure injury which is now resolving, and the other was acquired prior to admission which has since been proved not to be a pressure injury. A section 31 had been completed for a stage three pressure injury.	i) One pressure injury wound care chart did not indicate the stage of the pressure injury on any of the assessment forms sighted. ii) One wound care chart sighted for pressure injury had not been updated to reflect the wound was not pressure related.	i) Ensure all wound care charts are fully completed to include pressure injury stage. ii) Ensure all wound charts are updated to reflect changes. 60 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.