

Munro Resthomes Limited - Malyon House

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:	Munro Resthomes Limited	
Premises audited:	Malyon House	
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)	
Dates of audit:	Start date: 26 February 2020	End date: 26 February 2020
Proposed changes to current services (if any):	No	
Total beds occupied across all premises included in the audit on the first day of the audit:	56	

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

Malyon House provides rest home and hospital level care for up to 57 residents and on the day of the audit there were 56 residents. The service is managed by a managing director and a clinical manager. The residents and relatives interviewed spoke positively about the care and support provided.

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

This audit identified that improvements are required around meeting minutes and wound management.

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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Residents are provided with information they need on entry to the service and this is regularly updated. Interviews with residents and family confirmed they are provided with adequate information and that communication is open. Family members stated that they are informed of any change of care or incident related to their family member when this occurs.

Residents are informed of the complaints process and there are policies and procedures in place to investigate complaints with these investigated in a timely manner.

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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There is a clinical manager and managing director who provide operational and clinical management and leadership for the service.

There is a documented quality and risk management programme. Adverse, unplanned, and untoward events are documented by staff and reviewed by the managing director or clinical manager. The health and safety programme is implemented.

Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. An annual staff education and training plan is well attended with all staff attending mandatory training annually.

Staffing is relevant and appropriate to the number and acuity of residents in the facility. The service has a full complement of registered nurses with a casual registered nurse available to provide cover if a registered nurse is on leave. Registered nursing cover is provided on all shifts in the hospital building at all times.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Initial assessments and interRAI assessments are completed on admission to the service. Care planning and reviews 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 and a nurse practitioner review residents at least three monthly or more frequently if needed. Meals are prepared on site. The menu is varied and appropriate. Individual and special dietary needs are catered for. Alternative options are provided. Residents 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 has a current warrant of fitness. Preventative and reactive maintenance occurs.

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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Restraint minimisation and safe practice policies and procedures are in place. Staff receive training in restraint minimisation and management of challenging behaviour management. On the day of audit there were no residents using restraint. One resident uses an enabler.

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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A surveillance programme is documented and undertaken, and this is appropriate to the size and complexity of the service. Results of surveillance are reported to relevant personnel in a timely manner. There have been no outbreaks since the previous audit.

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	14	0	1	1	0	0
Criteria	0	39	0	1	1	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	<p>The service has a complaints policy that describes how complaints are managed and is in line with requirements set by the Health and Disability Commissioner (HDC). The complaints process is linked to the quality and risk management programme. Complaints forms are available at the entrance to the facility. Information about complaints is provided on admission.</p> <p>Interviews with residents and family members confirmed that they understand the complaints process. They also confirmed that management and staff are approachable and readily available if they have a concern. Four complaints were documented in 2019 and two to date in 2020. All complaints reviewed for 2020 have been resolved in a timely manner as per policy. A review of the complaints register evidenced that the appropriate actions have been taken and the complainant received documented outcome of the complaint.</p>
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment	FA	<p>There is a policy to guide staff on the process around open disclosure. Residents and family are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement. Information is provided in formats suitable for the resident and their family.</p> <p>Seven residents (four hospital and three rest home) and five relatives (three hospital and two rest home) interviewed, confirmed that the staff and management are approachable and available. Fifteen incident forms reviewed identified family were notified following a resident incident. Relatives interviewed confirmed they are</p>

conducive to effective communication.		notified of any incidents/accidents. Families are invited to attend the three-monthly resident/family meetings and there are also family meetings offered twice a year. Interpreter services are available as required.
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Malyon House is owned and operated by Munro Rest Homes Limited. The service provides rest home, hospital (geriatric and medical) level care for up to 57 residents. Eight beds are identified as rest home level care only and the remaining forty-nine are dual purpose beds. On the day of audit, there were 56 residents (16 residents receiving rest home level care and 40 receiving hospital level care (including one younger person under the LTS-CHC contract and one resident on palliative care). All other residents were under the Age-Related Residential Care (ARRC) contract.</p> <p>Malyon House has a 2019-2020 business/strategic plan, philosophy of care and mission statement which links to the organisation's strategic plan and is reviewed monthly with the directors. The managing director (owner of the service) reports to the Board regularly on a variety of operational issues.</p> <p>The managing director is a registered nurse and has experience in haematology at the district health board. They took over as facility manager in mid-2017 and in 2018 purchased the service from family following the retirement of the then managing director with a move to the role they are currently in. One family member maintains support for the service by providing oversight for health and safety and food services.</p> <p>The managing director is supported by a clinical manager who has been in the position for over one year. A section 31 notification was completed for the change from facility manager to managing director.</p> <p>The managing director had completed a minimum of eight hours of professional development relating to the management of an aged care service in the past twelve months.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	PA Low	<p>Quality and risk management systems are in place. Interviews with care staff (four carers working across the rest home and hospital; two registered nurses; the diversional therapist) and a sample of other staff including the administrator, cook and managers confirmed their understanding of the quality and risk management programmes.</p> <p>There are policies and procedures being implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. The content of policy and procedures are detailed to allow effective implementation by staff. A document control system to manage policies and procedures is in place. Policy review is discussed with the managers of four other aged care services.</p> <p>Data is collected in relation to a variety of quality activities. The quality and risk management programmes include an internal audit programme which is implemented with evidence that corrective action plans and</p>

		<p>resolution of issues is documented. Clinical data is tabled at various staff meetings including the registered nurse, staff and staff meetings. Staff and managers stated that there is discussion of the clinical data however this discussion could be better documented. Data is compared with five other aged care facilities with similar profiles.</p> <p>Meetings for groups of staff are held to ensure that the quality and risk management system is able to be discussed and understood. Meetings include management meetings, staff, health and safety and clinical meetings. If staff are not able to attend relevant meetings, they must sign a form to state that they have read and understood the minutes. Not all corrective actions raised at a meeting show evidence of resolution of the issue.</p> <p>The health and safety programme includes policies to guide practice. Staff accidents and incidents and identified hazards are monitored. One of the directors is the health and safety officer and has completed the specific health and safety training required. There is a health and safety/WorkWell leadership team monthly meeting with a focus on promoting safe work habits amongst employees. Health and safety is also discussed at the staff and management meetings. Falls prevention strategies are in place including the analysis of falls and the identification of interventions on a case-by-case basis to minimise future falls.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>There is an incident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective actions. The service collects a set of data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information. The data is trended and linked to the quality management systems (refer 1.2.3.6). Incident and accident data is tabled at relevant meetings including health and safety, clinical, management and staff meetings. Fifteen accident/incident forms sampled from February 2020 included registered nurse assessment following an incident. When there was an unwitnessed fall or a resident had fallen and hit their head, there was evidence that neurological observations had been taken as per policy.</p> <p>Eight section 31 forms had been sent to the Ministry of Health between 4 November 2019 and 6 January 2020. All related to a shortage of registered nurses with the managing director or clinical manager documented as providing cover while a nurse was on leave. A further section 31 form was sent to the Ministry advising them of a change in facility manager to managing director. The service now has a full complement of registered nurses with one casual registered nurse available to provide cover. The service continues to recruit for registered nurses to provide support while others are on leave.</p>
<p>Standard 1.2.7: Human Resource Management</p>	FA	<p>There are job descriptions available for all relevant positions that describe staff roles, responsibilities and accountabilities. The practising certificates of nurses are current. The service also maintains copies of other</p>

<p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>visiting practitioners practising certificates including general practitioner (GP), pharmacist and physiotherapist.</p> <p>Nine staff files were reviewed (one clinical manager, one cook, one diversional therapist, three registered nurses and three carers). Evidence of signed employment contracts, reference checking, job descriptions, orientation and training were sighted. Annual performance appraisals for staff are conducted for all employees.</p> <p>Newly appointed staff complete an orientation that is specific to their job duties. Interviews with carers described the orientation programme that includes a period of supervision/buddying of the new employee.</p> <p>The service has a training policy and a scheduled in-service education planner. The in-service schedule is implemented, and attendance is recorded. Each employee is required to attend an annual training day along with other training offered throughout the year. The annual study day is offered bi-monthly to ensure that all staff can attend. Staff also complete annual competencies relevant to their roles. Registered nurses and some senior caregiver's complete medication competencies. Other competencies include restraint and the use of a syringe driver. Five of the ten registered nurses are interRAI trained. Registered nurses also attend district health board training offered whenever possible.</p> <p>Four caregivers have completed level two Careerforce training (four also enrolled; seven have completed level three training and 12 have completed level four training.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. Sufficient staff are rostered to manage the care requirements of the residents. The managing director and clinical manager both work full-time from Monday to Friday and share the 24/7 on call duties. Extra staff can be called on for increased resident requirements. Interviews with staff, residents and relatives confirmed that there are sufficient staff on duty.</p> <p>The facility is split into the ground floor (Ruby, Sapphire, Jade and Topaz wings) and upstairs (Opal and Amber wings).</p> <p>On the ground floor, there are a total of 35 residents (25 hospital and 10 rest home residents). This includes residents in the following wings: Topaz: six rest home and two hospital residents; Ruby: two rest home and five hospital residents (one vacancy); Jade: one rest home and seven hospital residents; Sapphire: one rest home and eleven hospital residents. Upstairs there are two wings with a total of 21 residents (six rest home and 15 hospital). This includes Opal: two rest home and nine hospital residents; Amber: four rest home and six hospital residents.</p> <p>Staff are allocated to each wing/s as follows:</p> <p>Morning shift. Topaz and Ruby: three carers including one short shift, Jade: one carer long shift, Sapphire:</p>

		<p>three carers including one floating, Opal and Amber (upstairs): three carers and one short shift.</p> <p>Afternoon shift. Topaz, Jade and Ruby: three carers including one short shift, Sapphire: two carers, Opal and Amber (upstairs): three carers.</p> <p>Night shift. One carer downstairs and one upstairs with a registered nurse floating between floors.</p> <p>There is one registered nurse on duty on each shift.</p> <p>Staff interviewed stated that they work as a team with senior staff supporting newer staff. All confirmed that senior care staff articulate a plan for the shift, and this ensures that residents are able to meet their needs and activities.</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>Ten electronic medication charts reviewed had photo identification and an allergy status on the medication chart. Medication prescribed is signed as administered on the electronic system, there is evidence of three-monthly reviews by the GP.</p> <p>Medication competent caregivers and RNs who are responsible for medication administration have completed medication competency annually. Medication administration practice complies with the medication management policy for the medication round sighted. Medications are checked on delivery against the medication chart by the RN. Standing orders are in place and updated six monthly.</p> <p>The facility uses a pre-packaged medication management system. One resident self-administers an inhaler and has a current competency assessment, which has been reviewed six monthly by the GP.</p> <p>All medications were stored safely in a locked cupboard in the nurses' station. The medication fridge is monitored daily as sighted in records reviewed. Medication room temperatures were checked and recorded daily and were under 25 degrees. Short time medications (eg, eye drops) were dated when opened.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>There is a functional kitchen in the basement, all food is cooked on site. The kitchen is able to meet the needs of residents who require special diets and the cook works closely with the RN. The cooks and kitchenhands have completed food safety training.</p> <p>The cook follows a rotating menu which has been reviewed by a dietitian. Supplements are available for residents who experience unintentional weight loss or require weight maintenance. There is special equipment available for residents if required.</p> <p>A food control plan is in place expiring on 30 September 2020. The temperatures of refrigerators and freezers are recorded daily and were within ranges. Cooked foods are monitored and recorded. All food is stored appropriately and is dated to ensure good stock rotation. Cleaning schedules are in place and are adhered to.</p>

		Residents interviewed were very happy with food service provided.
<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 Moderate</p>	<p>When a resident's condition alters, the registered nurse initiates a review and if required, GP or nurse specialist consultation. There is evidence that relatives were notified of any changes to their relative's health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications. Discussions with relatives and notifications are documented in the resident files reviewed. There is pressure relieving equipment in place, hoists and adequate dressing supplies.</p> <p>There were three pressure injuries; one grade one facility acquired pressure injury and two stage two facility acquired pressure injuries. There were 35 wounds with wound assessments, plans and evaluations in place. There is access to a wound nurse specialist from the DHB if required.</p> <p>Initial assessments and management plans for wounds are in place for residents as well as management plans. While practice has improved since the previous audit when there were issues identified around assessment, plans and review of plans for any wound documented. There is insufficient evidence to confirm that wound care dressings are completed as specified in the wound care management plan. The risk rating was initially documented as low and this has been raised to a moderate risk</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified.</p> <p>Monitoring occurs for blood pressure, weight, vital signs, pain, repositioning and challenging behaviours as required. All monitoring forms were appropriately completed.</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 service.</p>	<p>FA</p>	<p>There is an activities team that includes a diversional therapist, two activities team therapists and five volunteers. The activities team provide activities seven days a week for rest home and hospital residents. The activities include (but are not limited to) bingo, exercises, cross words, word search and happy hour. One to one activities are also provided for residents who do not attend the group activities.</p> <p>Community visitors include canine friends, kindergarten and day care groups, entertainers and church groups. Outings in the facility van include a monthly lunch trip to the nearby RSA club, visits to the Waihi steam train museum, visits to watch cruise ships leave the harbour, picnics, concerts and residents cook and take meals to the homeless once a month.</p> <p>Resident life experiences and activity assessments are completed for residents on admission. The activity plans in the files reviewed had been evaluated at least six-monthly with the care plan review. The residents/family/whānau (as appropriate) are involved in the development of the activity plan. Residents/relatives can feedback on the programme through the monthly resident meetings in each unit and</p>

		relative meetings and satisfaction surveys. Residents/relative interviewed were very happy with the activities offered.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	All initial care plans reviewed were evaluated by the RN within three weeks of admission. Files sampled demonstrated that the long-term care plan was evaluated at least six-monthly or earlier if there is a change in health status. Short-term care plans sighted were evaluated and resolved or added to the long-term care plan if the problem was ongoing, as sighted in resident files sampled. Written evaluations identified if the desired goals had been met or unmet. The GP reviews the residents at least three monthly or earlier if required.
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 building has a current warrant of fitness expiring on 3 August 2020. All equipment has been tested and calibrated. There is a reactive and preventive maintenance schedule. All resident rooms are personalised to personal taste. There are adequate shared toilet and shower rooms available for residents. All areas are accessible to residents requiring mobility aids. The external garden areas are accessible, well maintained and provide seating and shade.
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 (clinical manager) collates information obtained through surveillance to determine infection control activities and educational needs in the facility (link to 1.2.3.6). Infection control data including trends is tabled at management, staff and clinical meetings. Data is compared with five other facilities with similar profiles. Meeting minutes including graphs are available to staff. Systems in place, are appropriate to the size and complexity of the facility. There have been no outbreaks since the last audit.
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. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. Interviews with the staff confirmed their understanding of restraints and enablers. At the time of the audit, the service did not have any residents using restraint. One resident requested bedrails as an enabler to ensure that they felt safe. Staff training has been provided around restraint minimisation and management of challenging behaviours.

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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 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	PA Low	The complaints register and audit programme shows evidence of resolution of issues when these are raised. Issues are also raised at staff, management, clinical and other meetings and there is limited evidence documented that shows resolution of issues. The managing director stated that this is because the style of formatting minutes is to ‘drop off the issue’ when it has been resolved.	Meeting minutes do not show evidence of resolution of issues.	<p>Document evidence of resolution of issues in meeting minutes.</p> <p>180 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</p>	PA Moderate	Wound assessments and management plans are in place for residents, however not all wound dressings were completed as specified in the wound care management plan.	Three wound dressings, including two wounds and one pressure injury were not completed as was specified in the wound	Ensure wound care dressings are completed as specified in the wound care management

needs, and desired outcomes.			care management plan.	plan 60 days
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Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, 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

End of the report.