

# Kyber Health Care Limited - Waikiwi Garden Rest Home

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## Introduction

This report records the results of a Surveillance Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

<b>Legal entity:</b>	Kyber Health Care Limited
<b>Premises audited:</b>	Waikiwi Gardens Rest Home
<b>Services audited:</b>	Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 7 October 2019 End date: 8 October 2019
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	39

# Executive summary of the audit

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## Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

### Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

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

## General overview of the audit

Waikiwi Gardens provides care for up to 42 rest home level residents. On the day of the audit there were 39 residents. The facility is owned by two owner/directors (husband and wife) who have the responsibility of the daily operations, finance, maintenance and overseeing the delivery of services. They are supported by two full-time RNs, a part-time RN and a non-clinical manager and assistant manager.

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

The service has addressed one of the two shortfalls from the previous audit around maintenance. There continues to be an improvement required around incident reports.

This surveillance audit identified shortfalls around quality, aspects of incident reporting, and monitoring charts.

## 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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A policy on open disclosure is in place. There is evidence that residents and relatives are kept informed. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service. A system for managing complaints is in place.

## 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 medium or high risk and/or unattained and of low risk.
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A quality and risk management programme is documented. The risk management programme includes managing adverse events and health and safety processes. There is a 2019 business plan in place. Quality management processes are reflected in the businesses plan's goals and objectives. Staff document incidents and accidents. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. Ongoing education and training is in place, which includes in-service education and competency assessments. Residents and relatives reported that staffing levels are adequate to meet the needs of the residents.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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Registered nurses are responsible for care plan documentation. InterRAI assessments reviewed are completed within required timeframes. Planned activities are appropriate to the resident's assessed needs and abilities. Residents and relatives advised satisfaction with the activities programme. The service uses an electronic medication management system. 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

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 service has a current building warrant of fitness and reactive and preventative 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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Waikiwi Gardens has restraint minimisation and safe practice policies and procedures in place. Staff receive training in restraint minimisation and challenging behaviour management. The service currently has no residents requiring restraint and one resident who had requested bedrails as enablers.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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Waikiwi Gardens continue to implement their infection surveillance programme. Infection control issues are discussed at both the management and combined quality/staff meetings. The infection control programme is linked with the quality programme.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	0	13	0	2	1	0	0
<b>Criteria</b>	0	38	0	2	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>Complaints forms are available at the entrance of the dining room. Information around the complaints process is provided on admission. A record of all complaints, both verbal and written is maintained by the facility manager on the complaints register. Two complaints received since the previous audit (both 2018) were reviewed. Documentation reflected evidence of responding to the complaints in a timely manner with appropriate follow-up actions taken. Caregivers interviewed confirmed that complaints and any required follow-up is discussed at staff meetings. Residents and relatives advised that they are aware of the complaints procedure and how to access forms.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Comprehensive information is provided at entry to residents and family/whānau. Four residents interviewed stated that they were welcomed on entry and were given time and explanation about the services and procedures. The owners, the manager and the registered nurses are available to residents and relatives and they promote an open-door policy. Incident forms reviewed in August and September 2019 evidenced that relatives had been notified on all occasions or if the relative indicated they did not wish to be informed. Three family interviewed advised that they are notified of incidents and when residents' health status changes.</p>



<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>	<p>FA</p>	<p>Waikiwi Gardens rest home provides care for up to 42 rest home level residents. On the day of audit there were 39 residents, including two residents on a 'younger persons with disabilities' (YPD) contract and one on a long-term support - chronic health condition (LTS-CHC). All other residents are under the age-related residential care (ARRC) agreement. There were five independent boarders living within the rest home who are independent and do not receive care services.</p> <p>The facility is managed by two owner/directors (husband and wife). One is responsible for the operational/staff management and the other is responsible for the maintenance/property requirements. The owner/directors (both non-clinical) have owned the rest home since March 2017. They are supported by two full-time RNs and one part time RN who are responsible for overseeing the clinical service. They are also supported by a non-clinical manager and assistant manager who coordinates and oversees quality activities and human resources.</p> <p>A business plan is in place for 2019 which identifies the purpose, vision, direction, scope and goals for the service, these are discussed regularly and evaluated annually.</p> <p>The management team have maintained at least eight hours of professional development in relation to management of a rest home.</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>	<p>PA Low</p>	<p>Waikiwi Gardens rest home has a quality and risk programme in place for 2019. Policies and procedures are maintained by a recognised aged care consultant, who reviews policies to ensure they align with current good practice and meet legislative requirements.</p> <p>There are monthly quality/staff meetings which include discussions around health and safety issues, infection control and incident data. Management meetings are held monthly. Staff and management meetings have been completed as per the scheduled calendar. The meeting minutes identified that not all quality data has been discussed.</p> <p>There is a 2019 internal audit programme that covers all aspects of the service including environmental, food service, cleaning service, resident care and documentation. Corrective actions for partial compliance are developed, implemented and signed off by the manager.</p> <p>The owner/director and manager are the health and safety officers and have completed the specific health and safety training required. Health and safety is discussed at the staff and management meetings. Staff complete hazard identification forms for identified/potential hazards. There is a current hazard register which is reviewed on an annual basis. Falls prevention strategies are implemented for individual residents and staff receive training to support falls prevention.</p> <p>Resident satisfaction surveys for 2018 and 2019 were conducted using a sample of only three residents. The shortfalls were discussed at the management meeting and corrective actions were in place to address</p>

		<p>the shortfalls. The shortfalls from 2018 were addressed with satisfaction rates improving, but still some work to be done around the menu and food services. Overall the residents interviewed were happy with activities and meals.</p> <p>Resident meetings are monthly and provide residents with a forum for feedback on the services. The owner/director and assistant manager facilitate the resident meetings. The minutes included an accurate reflection of the discussion/outcomes of the meetings, including follow-up to actions taken as matters arising.</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>	<p>PA Moderate</p>	<p>The service collects incident and accident data which are discussed at the quality/staff meeting. Discussions with the owner and the manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been no notifications made since the previous audit.</p> <p>Ten incident forms were reviewed for the month of August. Documentation of the incident reports is commenced by the caregivers or the first on the scene. NOK were notified or the reason why the NOK was not informing relatives was documented. The incident reports reviewed documented the RN follow-up, however, neurological observations were not always completed for residents whose falls were unwitnessed (an ongoing shortfall), and not all forms identified opportunities to minimise future risks. There is a monthly analysis of incidents for the month with a comparison to the previous month which is discussed at staff/quality meetings.</p> <p>The caregivers interviewed could describe the incident reporting process.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>There are human resources policies to support recruitment practices. A list of practising certificates is maintained. Five staff files were reviewed (one registered nurse, one cook, two caregivers, one activities coordinator) who have all been employed since the previous audit. All had relevant documentation relating to employment, and appraisals.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme includes documented competencies and induction checklists (sighted in files of newly appointed staff). Staff interviewed were able to describe the orientation process and believed new staff were adequately orientated to the service.</p> <p>There is an education plan that is being implemented that covers all contractual education topics and exceeds eight hours annually. There is evidence on RN staff files of attendance at external training days. Interviews with four caregivers, confirmed participation in the Careerforce training programme is offered and encouraged at each appraisal, however there is a low uptake. A competency programme is in place that includes annual medication competency for staff administering medications. Competency questionnaires</p>

		were sighted in files reviewed.
<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>	FA	<p>Waikiwi Gardens has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. The owners and the manager (non-clinical) works 40 hours per week and is supported by a part time assistant manager (non-clinical).</p> <p>There are two full time RNs and one RN works three days a week. Typically, there are two RNs on duty Monday to Wednesday (1 x 8 am to 4 pm and 1x 9 am to 5 pm), and one RN on Thursday and Friday. The RNs share on call after hours and weekends.</p> <p>There are two caregivers who work 6 am to 2 pm, one works 7 am to 11 am on the morning shift.</p> <p>The afternoon shift has two caregivers working 2 pm to 10 pm and on 4 pm to 7 pm.</p> <p>There are two caregivers covering the nightshift from 10 pm to 6 am.</p> <p>There is a minimum of one care staff with a current first aid certificate on every shift.</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>Waikiwi Gardens use an electronic medication management system. The supplying pharmacy delivers all medicines in blister packs for regular medications and PRN medications. Medications were checked and signed on arrival from the pharmacy.</p> <p>Registered nurses and medicine competent caregivers administer medication. Medicine competencies are completed annually. Standing orders were not in use. The medication fridge temperatures have been monitored daily and temperatures were within the acceptable range. Ten medication files were reviewed. Medication reviews were completed by the GP three monthly. PRN medications were prescribed correctly with indications for use. Medications are stored securely in a designated medication room. Controlled drug medications are appropriately stored. There was one resident who was independent with one medication. A competency was in place and had been reviewed by the GP three monthly. Medications were stored securely in the resident's room.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual</p>	FA	<p>There is a functional kitchen and all food is cooked on site. There is a food services manual in place to guide staff. All staff working in the kitchen have food safety certificates (NZQA). Food is served from the main kitchen to the dining area adjacent to it. An application has been made for a food control plan.</p> <p>Special diets are being catered for. The four weekly seasonal menu was designed and reviewed by a</p>

<p>food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>registered dietitian recently. Residents have had a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. This is reviewed six monthly as part of the care plan review or sooner if required. The kitchen staff are aware of changes in resident's nutritional needs.</p> <p>Regular audits of the kitchen fridge/freezer temperatures and food temperatures were undertaken and documented. All food is stored appropriately, and cleaning schedules are maintained. There is special equipment available for residents if required. Residents and relatives interviewed reported satisfaction with food choices. Food services were discussed at the resident meetings in the minutes reviewed.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Low</p>	<p>The registered nurse and caregivers follow the care plan and report progress against the plan each shift. Short-term care plans were in place for short-term needs, and reviewed in a timely manner, and added to the long-term care plan if the concern was ongoing.</p> <p>Staff have access to sufficient medical supplies (eg, dressings). Wound assessments, plans and evaluations were in place for seven wounds (including two chronic wounds). However, these were not always completed correctly. There were no residents with pressure injuries on the day of the audit. The wound care specialist nurse is available on request.</p> <p>Sufficient continence products are available and resident files included a continence assessment and plan. Specialist continence advice is available as needed and this could be described.</p> <p>Weights were recorded monthly, included in the care plan interventions and were evaluated by the RNs, identifying any resident with issues. The dietitian is available on referral.</p> <p>Monitoring charts available include (but not limited to), vital signs and weight, behaviour, restraint/enabler, blood sugar levels and neurological signs. Monitoring charts were not always completed as instructed in the care plan or as identified in the progress notes.</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>Waikiwi Gardens employ an activities coordinator over 24 hours a week and covers the occasional Saturday. The activities coordinator was not available on the day of the audit. The manager and the owner were interviewed. The resident files reviewed all included a social history and assessment which was completed shortly after admission, an activities plan, and six-month reviews were all documented. A monthly progress note was documented to update attendance.</p> <p>A monthly planner is planned with the activities' coordinator, the manager and owner. All recurring activities such as planned entertainment, kindergarten groups, tea and tots' group, newspaper reading, games etc are all entered, and then other activities are planned to complete the programme. The residents go on outings of their choosing. Activities take place in the main lounge and in the smaller lounge for quieter one-on-one</p>

		<p>activities for more dependant residents. Individually tailored activities are planned for residents under 65, who also have the opportunity to be involved in the regular activities. One resident attends choir and activities at the blind foundation.</p> <p>Residents provide suggestions at the resident meetings (sighted in the minutes) which are accommodated as far as possible. The residents and relatives interviewed were complimentary of the activity programme and felt there was plenty variety on offer.</p> <p>Waikiwi provide a social senior group, where people from the community join the residents for the day, have lunch and transport is provided.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Initial care plans reviewed were evaluated by the RN within three weeks of admission. Short-term care plans were evidenced in the sampled files reviewed as clinically indicated. Residents were reviewed at least three monthly by the GP. Care plans were evaluated six-monthly or more frequently when clinically indicated, and documented progression towards meeting the residents' goals.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building has a current building warrant of fitness that expires 1 February 2020. The maintenance person ensures daily maintenance requests are addressed and a planned maintenance schedule is maintained. Hot water temperature recordings reviewed were within expected range.</p> <p>The building is two levels. The upstairs level is reserved for residents who are able to manage the stairs independently (currently five of the seven rooms upstairs are occupied by independent boarders).</p> <p>There is safe access to the outdoor areas, and the gardens are well maintained. Seating areas and shade is provided. There is a designated outdoor smoking area. The facility has corridors with sufficient space for residents to safely mobilise using mobility aids. There is one large lounge where residents can watch TV or participate in activities, and one smaller lounge which is also available for smaller activities.</p> <p>The RNs and caregivers interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans, including hoists and pressure injury prevention equipment.</p> <p>The previous finding from the certification audit around the stretched carpet in two areas, has been addressed, the carpet in these areas has been replaced. Three of the four corridor carpets have been replaced, the remaining carpet is in the budget for replacement. The remaining carpet to be replaced does not pose as a trip hazard for residents.</p>

<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Waikiwi Gardens continue to implement their infection surveillance programme. Individual infection report forms were completed for all infections. Infections were included on a monthly register and a monthly report was completed by the infection control coordinator. Monthly statistics are analysed and compared with previous months. Infection control (IC) issues were discussed at the management, and combined quality /staff meetings. The IC programme is linked to the quality programme.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>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 currently no residents using restraint and one resident has requested bedrails as enablers. Consent was in place and regular reviews have been occurring, however the monitoring form has not been completed (link 1.3.6.1).</p> <p>There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. Restraint/enabler and challenging behaviour training has been provided.</p>

## 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 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	PA Low	<p>Quality data discussed at staff meetings includes infections, accidents and incidents, and concerns/complaints. Staff are required to read and sign the minutes of the meetings if not able to attend. However, not all data is documented as being discussed at the combined staff/quality meetings.</p>	<p>i) Internal audits and corrective actions have not been documented as being discussed at the staff meetings.</p> <p>ii) Resident satisfaction surveys have only been distributed to a sample of three residents within the facility.</p>	<p>i) Ensure all quality data and corrective actions are discussed and included in the meeting minutes.</p> <p>ii) Ensure all residents and relatives have the opportunity to participate in resident surveys.</p> <p>180 days</p>

<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	<p>PA Moderate</p>	<p>Incident reports are completed for each adverse event. The forms included NOK notification and RN follow-up. However, not all incidents included the opportunity to minimise future risks, and not all unwitnessed falls had neurological observations recorded or reason for not recording these documented. This is an ongoing shortfall.</p>	<p>i) Nine of ten incident reports did not evidence the opportunity to minimise risk.</p> <p>ii) Neurological observations were not completed for four unwitnessed falls with a potential for head injury as per the policy.</p>	<p>i) Ensure the incident reports include the opportunity to minimise risks.</p> <p>ii) Ensure neurological observations are completed for unwitnessed falls as per policy.</p> <p>90 days</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Low</p>	<p>Wound assessments, plan and evaluations were in place for wounds and documented progression towards healing, however, these were not always completed correctly. Monitoring charts are available, however not always completed as instructed in the care plan or mentioned in the progress notes.</p>	<p>i) One wound chart documented more than one wound.</p> <p>ii) Two wound charts do not indicate what the wound is.</p> <p>iii) Monitoring charts were not in place for monitoring enabler bedrail or changes in resident position (same resident) as per instructions in the care plan.</p>	<p>i) – ii) Ensure all wound charts are completed fully to indicate the type of wound and only one chart per wound.</p> <p>iii) Ensure all monitoring charts are completed as per the care plan instructions.</p> <p>90 days</p>



## Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display
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End of the report.