

Mercy Parklands Limited

Current Status: 8 May 2014

The following summary has been accepted by the Ministry of Health as being an accurate reflection of the Surveillance Audit conducted against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) on the audit date(s) specified.

General overview

Mercy Parklands is owned by Mercy Healthcare Auckland, with the Sisters of Mercy Ministries New Zealand Trust being shareholders of the Mercy Healthcare group. Mercy Healthcare's Board role is to provide governance and leadership to Mercy Parklands. Mercy Parklands provides rest home and hospital level of care for up to 97 residents.

As part of the rest home and hospital services Mercy Parklands has specific contracts to provide for residents needing palliative care, orthopaedic interim care and care for younger residents under the age of 65. The service has a small non secure home environment area in one of its hubs to provide for residents with cognitive impairment.

One of the strengths of the service is their commitment to embrace and implement the 'Spark of Life' philosophy and approach to care. Mercy Parklands have gained recognition as the world's first 'Spark of Life' Centre of Excellence.

At the previous certification there were two areas requiring improvement, both of these have been addressed and implemented into practice (related to advance directives and staff orientation processes). From this surveillance audit there are two areas of excellence (continuous improvement rating) related to the quality systems and planned activities; and one area requiring improvement to the medicine management system.

Audit Summary as at 8 May 2014

Standards have been assessed and summarised below:

Key

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

Consumer Rights as at 8 May 2014

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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Organisational Management as at 8 May 2014

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.
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Continuum of Service Delivery as at 8 May 2014

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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Safe and Appropriate Environment as at 8 May 2014

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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Restraint Minimisation and Safe Practice as at 8 May 2014

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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Infection Prevention and Control as at 8 May 2014

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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HealthCERT Aged Residential Care Audit Report (version 4.0)

Introduction

This report records the results of an audit against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) of an aged residential care service provider. The audit has been conducted by an auditing agency designated under 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).

It is important that auditors restrict their editing to the content controls in the document and do not delete any content controls or any text outside the content controls.

Audit Report

Legal entity name:	Mercy Parklands Limited		
Certificate name:	Mercy Parklands Limited		
Designated Auditing Agency:	The DAA Group Limited		
Types of audit:	Surveillance Audit		
Premises audited:	Mercy Parklands Limited		
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical		
Dates of audit:	Start date: 8 May 2014	End date: 9 May 2014	
Proposed changes to current services (if any):			
Total beds occupied across all premises included in the audit on the first day of the audit:			97

Audit Team

Lead Auditor	XXXXXX	Hours on site	16	Hours off site	4
Other Auditors	XXXXX	Total hours on site	8	Total hours off site	4
Technical Experts		Total hours on site		Total hours off site	
Consumer Auditors		Total hours on site		Total hours off site	
Peer Reviewer	XXXXX			Hours	2

Sample Totals

Total audit hours on site	24	Total audit hours off site	10	Total audit hours	34
Number of residents interviewed	7	Number of staff interviewed	19	Number of managers interviewed	4
Number of residents' records reviewed	7	Number of staff records reviewed	7	Total number of managers (headcount)	4
Number of medication records reviewed	12	Total number of staff (headcount)	112	Number of relatives interviewed	6
Number of residents' records reviewed using tracer methodology	2			Number of GPs interviewed	1

Declaration

I, XXXXX, Director of Wellington hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of The DAA Group Limited, an auditing agency designated under section 32 of the Act.

I confirm that:

a)	I am a delegated authority of The DAA Group Limited	Yes
b)	The DAA Group Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise	Yes
c)	The DAA Group Limited has developed the audit summary in this audit report in consultation with the provider	Yes
d)	this audit report has been approved by the lead auditor named above	Yes
e)	the peer reviewer named above has completed the peer review process in accordance with the DAA Handbook	Yes
f)	if this audit was unannounced, no member of the audit team has disclosed the timing of the audit to the provider	Yes
g)	The DAA Group Limited has provided all the information that is relevant to the audit	Yes
h)	The DAA Group Limited has finished editing the document.	Yes

Dated Wednesday, 28 May 2014

Executive Summary of Audit

General Overview

Mercy Parklands is owned by Mercy Healthcare Auckland, with the Sisters of Mercy Ministries New Zealand Trust being shareholders of the Mercy Healthcare group. Mercy Healthcare's Board role is to provide governance and leadership to Mercy Parklands. Mercy Parklands provides rest home and hospital level of care for up to 97 residents (90 hospital and 7 rest home including three younger residents at the time of audit). As part of the rest home and hospital services Mercy Parklands has specific contracts to provide for residents needing palliative care, orthopaedic interim care and care for younger residents under the age of 65. The service has a small non secure home environment area in one of its hubs to provide for residents with cognitive impairment.

One of the strengths of the service is their commitment to embrace and implement the 'Spark of Life' philosophy and approach to care. Mercy Parklands have gained recognition as the world's first 'Spark of Life' Centre of Excellence.

At the previous certification there were two areas requiring improvement, both of these have been addressed and implemented into practice (related to advance directives and staff orientation processes). From this surveillance audit there are two areas of excellence (continuous improvement rating) related to the quality systems and planned activities, and one area requiring improvement to the medicine management system.

Outcome 1.1: Consumer Rights

Mercy Parklands supports and encourages full and frank communication with residents and family/whanau. This is evident in residents' files reviewed and confirmed during resident and family/whanau interviews.

Advance directives related to the resuscitation status of each resident are clearly identified on forms which meet legislative requirements. This was an area identified for improvement in the previous audit and is now fully attained.

The service has an easily accessed, responsive and fair complaints process. There is an up-to-date complaint register maintained that includes all complaints, dates, and actions taken.

Outcome 1.2: Organisational Management

Mercy Healthcare Board provides a role in the governance, leadership and strategic direction for Mercy Parklands. The Mercy philosophy, mission and values are to preserve and promote the dignity and worth of each of the residents. The service is managed by a suitably qualified and experienced chief executive officer (CEO) with extensive background in nursing and management. The CEO of Mercy Parklands reports to the CEO of Mercy Healthcare /Mercy Healthcare Board.

There are established quality and risk management systems. There is evidence that the quality and risk systems are effectively documented and continually improved over a number of years, with ongoing reviews, evaluation and benchmarking of results. The service has conducted several quality improvement projects resulting in the service being rated beyond full attainment and receiving a continuous improvement rating in this area.

Adverse events are effectively reported and managed to minimise risks to residents, staff and visitors. When adverse events or incidents occur, a review and reflection process is implemented and used to make improvements, where issues are identified.

The facility is divided into five wings or hubs, with staffing levels and skills mix of staff based on the needs of the residents in each of these hubs. The service has staff levels and a skills mix of staff that exceeds the minimum contractual requirements. Human resources and employment processes are conducted in accordance with good employment practices. Staff are provided with adequate orientation and ongoing education and training to ensure the needs of the service and residents are met. The Mercy Model of Care and 'Spark of Life' philosophy are incorporated into the ongoing education and training. The previous audit identified an area requiring improvement to ensure the ageing process is included in the orientation process, this has now been addressed.

Outcome 1.3: Continuum of Service Delivery

The organisation provides appropriate service provision which is resident centred. Each stage of service provision is undertaken by suitably qualified and experienced staff within timeframes to comply with contractual requirements and to ensure all residents' needs are met. Staff collaboration and team work is clearly identified. Changes to residents' needs are well responded to, and for temporary changes of care, a short term care plan is put in place.

Resident and family/whanau interviews confirm a high level of satisfaction with all services offered.

Mercy Parklands is a world leader in the delivery of services related to the 'Spark of Life' and this is clearly reflected in the activities programme offered. The activities programme supports the interests, needs and strengths of all residents, and has specific "Spark of Life" clubs available for residents with dementia. Documentation identifies the regularity of review and planning undertaken to meet residents' wants. This area meets all standard requirements to a higher level than normally expected and is rated as continuous improvement.

A safe and timely medicine management system is implemented by the service. Staff who administer medicines are competent to undertake the role. Two areas that require improvement relate to GP three monthly medication reviews not always being documented and the information regarding standing orders does not meet all the required standing order guidelines.

Residents express satisfaction with the food and fluid offered at the service. The menus have been approved by a registered dietician and individual resident reviews are undertaken as required.

Outcome 1.4: Safe and Appropriate Environment

The facility has a current building warrant of fitness. There have been no major changes to the layout of the facility or changes that are required to the evacuation plan since the last audit.

Outcome 2: Restraint Minimisation and Safe Practice

The facility demonstrates that the use of restraint is actively minimised. Enabler use is voluntary and the least restrictive option to meet the needs of the resident with the intent of maintaining safety and independence.

Outcome 3: Infection Prevention and Control

The results of surveillance of infections are analysed and reported to staff and management. The service works proactively to reduce infections and where

trends are identified, the service implements appropriate corrective actions. The infection surveillance data is externally benchmarked.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	1	15	0	1	0	0	0
Criteria	2	36	0	1	0	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
Standards	0	0	0	0	0	0	0	33
Criteria	0	0	0	0	0	0	0	62

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.3.12: Medicine Management	Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Low			
HDS(C)S.2008	Criterion 1.3.12.6	Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.	PA Low	<p>Time frames show that three monthly medicine reviews for six of the 12 medication charts reviewed exceed the required three month timeframe. Three charts are four months apart, two are five months apart and one is six months.</p> <p>Not all aspects of the standing orders sighted meet current legislative requirements.</p>	Ensure medicine review timeframes are met and that all instructions on standing orders meet legislative requirements.	180

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding
HDS(C)S.2008	Criterion 1.2.3.1	The organisation has a quality and risk management system which is understood and implemented by service providers.	CI	There is evidence from the review of a number of quality improvement projects that the quality and risk systems are continually reviewed, evaluated and improved. The service has gained recognition for becoming the first world centre of excellence for the implementation of the 'Spark of Life'. The organisation can demonstrate a number of innovative programmes that have impacted positively on the safety and satisfaction of residents. Staff at all levels of the organisation are involved in the implementation of the quality improvement projects.
HDS(C)S.2008	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.	CI	
HDS(C)S.2008	Criterion 1.3.7.1	Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.	CI	The service has a dedicated team of staff who ensure the activities provided maintain or improve resident strengths, skills and interests. Residents who have dementia are assessed and invited to a specific 'Spark of Life' club where the activity is appropriate for their level of ability, and specific 'Spark of Life' techniques are used to facilitate emotional wellbeing. Other clubs are also available for all residents of similar interest and focus that operate under the same "Spark of Life" principles, such as the Men's club, Young at Heart club, Art and Gardening clubs. There is also a full range of social activities that are available on the weekly programme. Groups, general activities, and outings are reviewed and evaluated both internally and externally via resident attendance numbers, regular staff discussions and planning days and family/whanau and resident satisfaction surveys. The results sighted are well above the mean scores when benchmarked against other like facilities. Having met all the requirements related to activities the organisation has gained a continuous improvement rating for this standard.

NZS 8134.1:2008: Health and Disability Services (Core) Standards

Outcome 1.1: Consumer Rights

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, facilitates informed choice, minimises harm, and acknowledges cultural and individual values and beliefs.

Standard 1.1.9: Communication (HDS(C)S.2008:1.1.9)

Service providers communicate effectively with consumers and provide an environment conducive to effective communication.

ARC A13.1; A13.2; A14.1; D11.3; D12.1; D12.3a; D12.4; D12.5; D16.1b.ii; D16.4b; D16.5e.iii; D20.3 ARHSS A13.1; A13.2; A14.1; D11.3; D12.1; D12.3a; D12.4; D12.5; D16.1bii; D16.4b; D16.53i.i.3.iii; D20.3

Attainment and Risk: FA

Evidence:

Policy and procedures guide the service provider's actions related to communication including the use of interpreter services as required. Interviews with 19 of 19 staff (the pastoral care coordinator, 10 health care assistants, four RNs, two cooks, one activities coordinator, and the infection control coordinator) confirm they understand the concept of open disclosure. This is confirmed by seven of seven (six hospital and one rest home level) residents and six of six family/whanau interviewed who report they are kept very well informed in a manner they understand.

Documentation sighted in seven of seven residents' files (six hospital and one rest home) identifies the sharing of information. There is a family/whanau contact page in residents' files where staff record conversations. Incident and accident forms sighted in residents' files show that any adverse events are reported to family/whanau as appropriate.

Criterion 1.1.9.1 (HDS(C)S.2008:1.1.9.1)

Consumers have a right to full and frank information and open disclosure from service providers.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.1.9.4 (HDS(C)S.2008:1.1.9.4)

Wherever necessary and reasonably practicable, interpreter services are provided.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.1.10: Informed Consent (HDS(C)S.2008:1.1.10)

Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.

ARC D3.1d; D11.3; D12.2; D13.1 ARHSS D3.1d; D11.3; D12.2; D13.1

Attainment and Risk: FA
Evidence: The previous audit identified an area for improvement at criterion 1.1.10.7 to ensure only valid not-for-resuscitation advance directives forms are held in residents' files. Mercy Parklands have developed and introduced a newly developed advanced directive form related to resident resuscitation status which meets all legislative requirements. The forms were sighted in seven of seven resident file reviews (six hospital and one rest home). Interviews with four of four RNs and the clinical nurse manager confirm advance directives are understood and acted upon where valid. This was an area identified for improvement in the previous audit and is now fully attained.

Criterion 1.1.10.7 (HDS(C)S.2008:1.1.10.7)

Advance directives that are made available to service providers are acted on where valid.

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.1.13: Complaints Management (HDS(C)S.2008:1.1.13)

The right of the consumer to make a complaint is understood, respected, and upheld.

ARC D6.2; D13.3h; E4.1biii.3 ARHSS D6.2; D13.3g

Attainment and Risk: FA

Evidence:

The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code. Complaints forms are accessible at the entrances to the service. The seven of seven residents (six hospital and one rest home) and six family/whanau interviewed report that these are easily accessible if they require them. Written and verbal complaints are recorded in the log. The complaints report form contains the dates of the complaint and the date the complaint is formally acknowledged, records if advice is given on the HDC complaints process and if the complaints brochure (which outlines the complaint process and access to advocacy services) is given, the nature of the complaint, investigations, actions and recommendations, and if the complainant was satisfied with the outcome. If the complaint is not resolved within 14 days, the complainant is notified of progress monthly (or more frequently if required).

An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken. The register records the date the complaint is reviewed, the description of the event, description of the corrective actions taken, review date and completion date. The complaints register records feedback and concerns received through the formal written complaints process, emails, letters, verbal, incident forms and improvement forms. There are no external complaints or investigations recorded. The complaints register is linked to the individual complaint checklist, which records additional information that includes the dates, responses, investigation, actions completed, and advice on Advocacy and Health and Disability Commissioner. The sample of the two complaints for 2014 records the time frames comply with Right 10 of the Code.

The ARRC requirements are met.

Criterion 1.1.13.1 (HDS(C)S.2008:1.1.13.1)

The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.1.13.3 (HDS(C)S.2008:1.1.13.3)

An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Outcome 1.2: Organisational Management

Consumers receive services that comply with legislation and are managed in a safe, efficient, and effective manner.

Standard 1.2.1: Governance (HDS(C)S.2008:1.2.1)

The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.

ARC A2.1; A18.1; A27.1; A30.1; D5.1; D5.2; D5.3; D17.3d; D17.4b; D17.5; E1.1; E2.1 ARHSS A2.1; A18.1; A27.1; A30.1; D5.1; D5.2; D5.3; D17.5

Attainment and Risk: FA
Evidence: <p>Mercy Parklands is part of the Mercy Healthcare Auckland Group. Mercy Healthcare Auckland is a subsidiary of Nga Whaea Atawhai o Aotearoa Sisters of Mercy Ministries New Zealand Trust to provide strategic leadership and governance. The Board of Mercy Healthcare Auckland is responsible for the stewardship of the Mercy Health Auckland group which includes Mercy Parklands. The mission and values of Mercy Parklands is ‘to care-enhancing human life through Mercy’s compassion and skill’. The purpose, values, direction and goals of the organisation are articulated in a number of documents and clearly displayed throughout the service. The mission and values of the organisation also appear in a number of places, such as resident information leaflets and posters in the residential facility. They are also articulated in documents such as the Mercy Model of Care and the ‘Spark of Life’ programme documents.</p> <p>Mercy Parklands is committed to providing a Mercy Model of Care that is holistic, encompasses and reflects the Mercy values, and enables each person to live with the</p>

Mercy vision. The Mercy Model of Care is documented as “a person centred approach which embraces a philosophy of collaboration and respectful partnership with all involved”.

Mercy Care provides proactive services that are accessible, flexible, coordinated and integrated within a loving and compassionate culture. Mercy Care is focussed on use of best practice to enhance and support individual abilities, values and choices.”

Mercy Parklands was recognised as the world’s first ‘Spark of Life’ Centre of Excellence in February 2014. Mercy Parklands have documented that in addition to enriching the emotional care of its residents; they also enjoyed the additional benefits of significantly reduced incidents of challenging behaviours and a reduction in falls (see the continuous improvement rating at 1.2.3.1).

Staff are informed of the mission and values, Mercy Model of Care and the ‘Spark of Life’ at orientation and through ongoing annual education. The management team interviewed confirm that the values and mission also form part of the performance review process (sighted in the seven of seven staff files reviewed).

The integrated business quality plan 2014-2015 has objectives related to quality and risk management as well as governance, mission, financial management, clinical management, allied health, human resources management, information management, facilities management, infection control, and specific projects. The integrated business and quality plans are last reviewed in January 2014.

The CEO of Mercy Parklands is a registered nurse with over 40 years’ experience and has been in the CEO role since August 2001. The CEO has post graduate qualification in business administration and is in a lead role within the aged care industry association. The CEO is supported by a management team which includes a service manager, allied health manager and clinical manager. The job descriptions sighted contain clear documentation of delegated authority. There are clear differences between the governance and management, and management and clinical roles and responsibilities.

The 19 of 19 staff interviewed from across all sectors of the service report excellent support from the CEO and the management team.

Criterion 1.2.1.1 (HDS(C)S.2008:1.2.1.1)

The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.1.3 (HDS(C)S.2008:1.2.1.3)

The organisation is managed by a suitably qualified and/or experienced person with authority, accountability, and responsibility for the provision of services.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.2.3: Quality And Risk Management Systems (HDS(C)S.2008:1.2.3)

The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.

ARC A4.1; D1.1; D1.2; D5.4; D10.1; D17.7a; D17.7b; D17.7e; D19.1b; D19.2; D19.3a.i-v; D19.4; D19.5 ARHSS A4.1; D1.1; D1.2; D5.4; D10.1; D16.6; D17.10a; D17.10b; D17.10e; D19.1b; D19.2; D19.3a-iv; D19.4; D19.5

Attainment and Risk: FA
Evidence: <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. The organisation has a quality and risk management system which is understood and implemented by the staff (confirmed at interview with the 19 of 19 staff from across all sectors of service delivery). Refer to the continuous improvement rating at 1.2.3.1.</p> <p>The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy. The organisation has completed a review of all policies and procedures and has now changed the formatting of these, which includes the integration of the policy and procedure into one document. The documents are referenced to best practice (e.g., from the Joanna Briggs Institute or from international programmes, such as the 'Spark of Life') and to current legislation. There is an effective system in place for identifying policies due for review and the updating of policies. The service manager confirms that staff receive notification when policies are updated.</p> <p>There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents. All documents are version controlled with staff having access to the current version of a document. Policies sighted are reflective of good practice.</p> <p>Key components of service delivery are explicitly linked to the quality management system. The quality and risk management system is closely linked with the health and safety, complaints management and infection control programme for the service through the internal auditing process. The internal audit system reviews practices and the key components of the service delivery.</p> <p>Quality improvement data is collected, analysed, and evaluated and the results communicated to staff and, where appropriate, residents and family/whanau. The</p>

organisation participates in a number of international benchmarking programmes, relating to employee and resident/family satisfaction, clinical record audits, clinical care components such as skin tears, resident falls, restraint, medication errors and infections. A comprehensive internal audit programme is in place (sighted) and is appropriate to the scope and mission of the organisation. This includes audits related to clinical care, human resources management, health and safety, support services, infection control, and restraint minimisation. The internal audit results are reported at the monthly quality meeting (minutes sighted). The results of projects and internal audits are also fed back to staff and displayed on notice boards for resident and family/whānau to read.

A process to measure achievement against the quality and risk management plan is implemented. There is a monthly Health Incorporated meeting that includes the review of the quality and risk process related to health and safety, infection control, safe handling and staff wellness. The Health Incorporated meeting includes the review of key improvements, risks and hazards and looks at new ideas and solutions for improvements. When indicated a corrective action plan addressing areas requiring improvement is developed and implemented

Actual and potential risks are identified, documented and where appropriate communicated to residents, their family/whānau and visitors. The risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk. A process that addresses/treats the risks associated with service provision is developed and implemented. The risk and hazard register sighted includes the identified risks, how these are monitored, and the severity of the risk and if the implemented actions can isolate, eliminate or minimise the risk. The risk register is maintained for each area of the service. The organisation has gained tertiary level recognition for the ACC Workplace Safety Management Practices programme in March 2014.

The 19 of 19 staff interviewed demonstrate understanding and involvement in the risk and quality management systems. The staff have an opportunity to participate in the quality and risk management systems by completing improvement suggestion forms and feeding back to the area/hub representative prior to the health incorporated meetings. The seven of seven residents report satisfaction with the services and delivery of care at Mercy Parklands.

The ARRC requirement is met.

Criterion 1.2.3.1 (HDS(C)S.2008:1.2.3.1)

The organisation has a quality and risk management system which is understood and implemented by service providers.

Attainment and Risk: CI

Evidence:

The achievement of Mercy Parklands quality and risk management system, which is understood and implemented by staff, is rated beyond the full attainment level. The service has conducted a number of quality improvement projects which involve a review process which includes analysis and reporting of findings. There is evidence of actions taken based on findings and improvement to service provision. The sampling of projects includes the 'Spark of Life', the specialist dementia wing, falls reduction programme and the restructuring of the wings in the service to create 'hubs'. The service has gained recognition for becoming the first world centre of excellence for the implementation of the 'Spark of Life'. The evaluation of these projects evidences positive results in residents' safety (47% reduction in falls and no challenging behaviours recorded since the establishment of a hub for residents with cognitive impairment) and resident and family satisfaction. The 2013 resident satisfaction survey indicates the service scored higher for all facilities that were involved in the external benchmarking (over 200 residential facilities in Australia and New Zealand). The outcomes of the quality project results are fed back to the board, staff, residents and family/whānau. The organisation quality and risk management systems are understood and implemented by the staff (confirmed at interview with the 19 of 19 staff from across all sectors of service delivery).

Finding:

There is evidence from the review of a number of quality improvement projects that the quality and risk systems are continually reviewed, evaluated and improved. The service has gained recognition for becoming the first world centre of excellence for the implementation of the 'Spark of Life'. The organisation can demonstrate a number of innovative programmes that have impacted positively on the safety and satisfaction of residents. Staff at all levels of the organisation are involved in the implementation

of the quality improvement projects.

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.2.3.3 (HDS(C)S.2008:1.2.3.3)

The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.2.3.4 (HDS(C)S.2008:1.2.3.4)

There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.2.3.5 (HDS(C)S.2008:1.2.3.5)

Key components of service delivery shall be explicitly linked to the quality management system.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.3.6 (HDS(C)S.2008:1.2.3.6)

Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.3.7 (HDS(C)S.2008:1.2.3.7)

A process to measure achievement against the quality and risk management plan is implemented.

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.2.3.8 (HDS(C)S.2008:1.2.3.8)

A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.2.3.9 (HDS(C)S.2008:1.2.3.9)

Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:

- (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;
- (b) A process that addresses/treats the risks associated with service provision is developed and implemented.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.2.4: Adverse Event Reporting (HDS(C)S.2008:1.2.4)

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.

ARC D19.3a.vi.; D19.3b; D19.3c ARHSS D19.3a.vi.; D19.3b; D19.3c

Attainment and Risk: FA

Evidence:

Health and Safety policy identifies the statutory and regulatory obligations in relation to essential notification reporting. A serious harm notification form and report template is available. The staff understand their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.

A review of 10 recent incident and accident reports identifies a wide range of incidents are reported by staff and data is collected to identify trends. If an area for improvement is identified through the events reporting process and complaints or internal audits, this is addressed through corrective action planning and includes quality projects. The overall review, evaluation and trending of the incidents records a reduction in resident falls, the review indicates there have been three incidents in 2014 that resulted in resident fractures. The allied health and clinical teams are now reviewing the results to investigate further interventions to reduce injury from falls. As part of the falls management programme there is reflective practice for staff to reflect on the incident and to help improve understanding of what occurred in order to ensure improvements are implemented in the provision of care in the future (one completed reflective practice form is sighted). The reflective practice includes the falls prevention coordinator reviewing the incident with the staff member and agreed outcomes to guide their practice in the future. Interviews with 19 of 19 staff confirm staff have a good understanding of reporting of adverse events.

The ARRC requirements are met.

Criterion 1.2.4.2 (HDS(C)S.2008:1.2.4.2)

The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.2.4.3 (HDS(C)S.2008:1.2.4.3)

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.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.2.7: Human Resource Management (HDS(C)S.2008:1.2.7)

Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.

ARC D17.6; D17.7; D17.8; E4.5d; E4.5e; E4.5f; E4.5g; E4.5h ARHSS D17.7, D17.9, D17.10, D17.11

Attainment and Risk: FA
Evidence: <p>The previous audit identified an area for improvement at 1.2.7.4 to review the orientation programme for healthcare assistants to ensure that training on the ageing process for staff who have not completed the training at the time of their appointment. This is now addressed and an area of improvement implemented since the previous audit.</p> <p>Professional qualifications are validated, including evidence of registration and scope of practice for the professional staff. Annual practising certificates are sighted for all staff that require them.</p> <p>There are processes implemented for the appointment of appropriate staff to safely meet the needs of residents. The seven of seven staff files reviewed demonstrate appropriate recruitment and employment processes. These include recruitment and employment process for advertising, interview process, reference checking and pre-employment vetting. There is a performance appraisal system, which is conducted at least annually for all staff. The newer staff also have a performance review after the first three months of employment.</p> <p>New staff receive an orientation/induction programme that covers the essential components of the service provided, which includes the ageing process (this is an improvement implemented since the last audit). The seven of seven staff files reviewed evidence an orientation and the 10 of 10 health care assistants (HCAs) interviewed confirmed they received an orientation that was effective in preparing them to work in the service. The orientation includes a comprehensive orientation to safe handling, when once completed the staff are deemed as competent for safe handling and gain a safe handling passport.</p> <p>There is a system in place to identify, plan, facilitate, and record ongoing education for staff to provide safe and effective services to the residents. The completed annual in-service schedule for 2014 is sighted. The education provided in 2013 and to date in 2014 is appropriate to rest home and hospital level of care and includes focus on</p>

the 'Spark of Life' approach, the Mercy Model of Care, palliative care and dementia care. All HCAs who do not have a national qualification are provided with access and support to gain their level three national qualifications in the support of the older person. The HCAs also have access to the internal competency pathway which are rated from levels one (basic care skills and beginning level competence) to level four (advanced care skills and competence). All staff are required to complete compulsory education topics annually and have the option to attend additional education and training (internal or external) relevant to their role.

The seven of seven residents (six hospital and one rest home) report satisfaction with the care provided.

The relevant ARRC requirements are met.

Criterion 1.2.7.2 (HDS(C)S.2008:1.2.7.2)

Professional qualifications are validated, including evidence of registration and scope of practice for service providers.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.2.7.3 (HDS(C)S.2008:1.2.7.3)

The appointment of appropriate service providers to safely meet the needs of consumers.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.2.7.4 (HDS(C)S.2008:1.2.7.4)

New service providers receive an orientation/induction programme that covers the essential components of the service provided.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.7.5 (HDS(C)S.2008:1.2.7.5)

A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.2.8: Service Provider Availability (HDS(C)S.2008:1.2.8)

Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.

ARC D17.1; D17.3a; D17.3 b; D17.3c; D17.3e; D17.3f; D17.3g; D17.4a; D17.4c; D17.4d; E4.5 a; E4.5 b; E4.5c ARHSS D17.1; D17.3; D17.4; D17.6; D17.8

Attainment and Risk: FA
Evidence: The workload monitoring policy records that the staffing levels are monitored to ensure appropriate numbers and skills of staff are available to achieve the resident's desired outcomes. This is based on industry accepted ratios, accepted best practice, legal requirements and qualifications of staff. Changes in workload are monitored to ensure the staff are capable of managing the volume and complexity of their caseload of residents. The service is divided into resident hubs and care staffing is allocated

per hub (wing) for the morning and afternoon shifts. Each of the five hubs has a nurse leader. At the time of audit there are 97 residents, (90 hospital and 7 rest home level of care): The sighted care staff roster includes:

- Hub 1 (a maximum of 16 residents, with the focus on palliative care in this hub): Morning shift there is one RN and three HCAs. The afternoon shift has one RN and two HCAs.
 - Hub 2 (maximum of 13 residents, with the focus on residents with dementia, though is not a secure unit): Morning shift and afternoon shifts there is one charge nurse (RN) and two HCAs on each shift.
 - Hub 3 (maximum 23 residents): Morning shift there is one RN and four HCAs and afternoon shift there is one RN and three HCAs.
 - Hub 4 (maximum of 18 residents): Morning shift and afternoon shifts has one RN and three HCAs on each shift.
 - Hub 5 (maximum of 26 residents): morning shift has one RN and four HCAs and afternoon shift has one RN and three HCAs.
- On night shift there is one RN and six HCAs (distributed for the five hubs) for the facility.

In addition to the above direct care staff there is a clinical manager (RN) and a clinical coordinator (RN), CEO (RN), Allied Health Manager to provide support, advice and guidance to staff during weekdays. There is a manager on call after hours. There are sufficient laundry (outsourced), cleaning and kitchen staff to meet the residents' needs. The organisation has an Allied Health Team of 11 staff which includes the manager who is an occupational therapist (OT), another OT, physiotherapist, two mobility therapists, an OT aid and five activities staff. There is also a pastoral care team with three staff. The service has a number of volunteers and the Sisters of Mercy that assist with activities and companionship for the residents.

The ARRC requirements are met.

Criterion 1.2.8.1 (HDS(C)S.2008:1.2.8.1)

There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Outcome 1.3: Continuum of Service Delivery

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.

Standard 1.3.3: Service Provision Requirements (HDS(C)S.2008:1.3.3)

Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals.

ARC D3.1c; D9.1; D9.2; D16.3a; D16.3e; D16.3l; D16.5b; D16.5c; D16.5c.ii; D16.5e ARHSS D3.1c; D9.1; D9.2; D16.3a; D16.3d; D16.5b; D16.5d; D16.5e; D16.5i

Attainment and Risk: FA

Evidence:

A review of seven of seven resident files (six hospital and one rest home) identifies that each stage of service provision is undertaken by suitably qualified and/or experienced service providers. The service has a suite of assessment tools which allow resident needs to be identified. Registered nurses, occupational therapists, physiotherapists and the pastoral care advisor all complete the appropriate assessment tools related to the service they oversee. This information is used to ensure appropriate care planning is documented to guide staff in the provision of service delivery. An initial short term care plan is put in place the day the resident enters the service and a long term care plan is developed over a three week period. All care plans are individualised to reflect each resident's needs, wants and likes and the actions to meet identified needs are clearly shown. Resident care plans are reviewed and evaluated every three months. Short term care plans are used for issues, such as infections, which are known to be resolved in a short time frame. Residents are reviewed medically within required timeframes following admission and then at least monthly.

The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate. Multidisciplinary reviews (MDR) occur six monthly. Resident and family/whanau interviews confirm they are very satisfied with services delivered. This is supported by the results of satisfaction surveys carried out throughout the year by both internal and external agencies. In one of the seven resident file reviews no documentation could be found for one of the 2013 six monthly MDRs. This is not a generic problem as all other reviews were located.

Verbal handovers are given between all shifts and there is a staff communication book to record upcoming appointments. Clinical staff confirm they are kept fully informed of any changes required to resident care. This is also shown in the care planning process as confirmed in seven of seven resident file reviews.

Interviews with seven of seven residents (six hospital and one rest home) and six of six family/whanau members identifies they are happy with the services provided and confirm they are kept informed of any concerns the staff may have. They confirm that they are included in all planning processes. One family/whanau member stated their relative did not attend any activities. When this was checked on the day of audit, documentation and the RN confirm that the resident regularly attends activities offered. This information was passed onto the family/whanau by the RN.

Tracer methodology for rest home level care

XXXXXX *This information has been deleted as it is specific to the health care of a resident.*

Tracer methodology for hospital level care

XXXXXX *This information has been deleted as it is specific to the health care of a resident.*

ARRC requirements are met.

Criterion 1.3.3.1 (HDS(C)S.2008:1.3.3.1)

Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.3.3.3 (HDS(C)S.2008:1.3.3.3)

Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.3.3.4 (HDS(C)S.2008:1.3.3.4)

The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.

Attainment and Risk: FA
Evidence:

Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.3.6: Service Delivery/Interventions (HDS(C)S.2008:1.3.6)

Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.

ARC D16.1a; D16.1b.i; D16.5a; D18.3; D18.4; E4.4 ARHSS D16.1a; D16.1b.i; D16.5a; D16.5c; D16.5f; D16.5g.i; D16.6; D18.3; D18.4

Attainment and Risk: FA
<p>Evidence:</p> <p>Individual resident needs are identified by use of appropriate assessment tools. Assessment information is used to develop interventions which are consistent with, and contribute to, meeting each resident’s needs. Interventions are well documented and outcomes are evaluated to monitor the achievement level gained towards resident goals. If a goal is not being met interventions are reviewed and changed as required. Staff interviews confirm they provide services/interventions that are described on each resident’s care plan and that if an intervention is not working they inform the RN who reassesses the resident and a new intervention is developed.</p> <p>Changes to service delivery are very well described in the seven of seven residents’ files reviewed. Examples found in the rest home care residents relate to activities being reviewed and implemented to meet the residents ‘change in mental acuity and the hospital level care resident relates to specific interventions being put in place post fracture.</p> <p>Interviews with six of six family/whanau and seven of seven residents (six hospital and one rest home) confirm the services provided meet all their current needs. One palliative care resident stated there is excellent family support and that they are absolutely happy with all the care and attention they receive to meet their needs.</p> <p>ARRC requirements are met.</p>

Criterion 1.3.6.1 (HDS(C)S.2008:1.3.6.1)

The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.3.7: Planned Activities (HDS(C)S.2008:1.3.7)

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.

ARC D16.5c.iii; D16.5d ARHSS D16.5g.iii; D16.5g.iv; D16.5h

Attainment and Risk: CI

Evidence:

At Mercy Parkland activities are planned and facilitated in a manner that develops and maintains resident strengths, skills and interests. Activities offered are meaningful to residents as confirmed during seven of seven resident interviews. This is also supported by the results sighted from an external audit agency who collated the results of the August 2013 family/whanau satisfaction survey which identifies that activities gained an average rating of 98% which is well above the mean. The April 2014 internal audit results also indicate that residents and family/whanau are very satisfied with the type and amount of activity offered.

Activities are overseen by the allied health manager who is an occupational therapist (OT) and is a registered 'Spark of Life' master practitioner. There are ten staff in the activities team who work a variety of hours to cover activities six days a week. The team includes a physiotherapist, OT assistants, an activities coordinator and mobility therapists, all these staff members have input into the activities planning process. Activities are advertised on the resident notice boards and a copy is delivered to every resident and sent to family/whanau electronically weekly.

Having met all the ARRC requirements related to activities the organisation demonstrates that it reviews, evaluates and is a world leader in the 'Spark of Life' methodology and has therefore gained a continuous improvement rating for this standard. (refer to CI at 1.3.7.1).

Criterion 1.3.7.1 (HDS(C)S.2008:1.3.7.1)

Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.

Attainment and Risk: CI

Evidence:

The service is recognised as the world's first 'Spark of Life' Centre of Excellence (February 2014). This is a whole systems approach which includes ensuring that all residents have activities available that are meaningful. Residents who have dementia are invited to attend specific clubs related to their abilities both physical and mental. There is a young at heart club for residents who wish to go out at night and a men's club which includes regular outing to the RSA among other places. Every day activities include craft group, crosswords, bingo, massage, gardening and entertainment.

Finding:

The service has a dedicated team of staff who ensure the activities provided maintain or improve resident strengths, skills and interests. Residents who have dementia are assessed and invited to a specific 'Spark of Life' club where the activity is appropriate for their level of ability, and specific 'Spark of Life' techniques are used to facilitate emotional wellbeing. Other clubs are also available for all residents of similar interest and focus that operate under the same "Spark of Life" principles, such as

the Men's club, Young at Heart club, Art and Gardening clubs. There is also a full range of social activities that are available on the weekly programme. Groups, general activities, and outings are reviewed and evaluated both internally and externally via resident attendance numbers, regular staff discussions and planning days and family/whanau and resident satisfaction surveys. The results sighted are well above the mean scores when benchmarked against other like facilities. Having met all the requirements related to activities the organisation has gained a continuous improvement rating for this standard.

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.3.8: Evaluation (HDS(C)S.2008:1.3.8)

Consumers' service delivery plans are evaluated in a comprehensive and timely manner.

ARC D16.3c; D16.3d; D16.4a ARHSS D16.3c; D16.4a

Attainment and Risk: FA

Evidence:

Evaluations are documented, resident focused and indicate the degree of achievement or response to the interventions put in place for each resident. The progress made toward meeting the documented desired outcomes is reported against. Updated information is sighted in seven of seven resident file reviews (six hospital and one rest home level) and evaluation of care is undertaken at a minimum of three monthly. If it is noted that a resident is not responding to an intervention, or there is a change in the resident's condition, reviews are undertaken more frequently.

Care evaluation is also undertaken with family/whanau and the resident six monthly. This meeting is a multidisciplinary review (MDR) process and all health care personnel who are involved in the residents care are asked for their input or to attend the meeting. Changes are made to care planning as appropriate or upon request from the resident or family/whanau. This is confirmed during interview with six of six family/whanau and seven of seven residents who report they feel involved in all care planning processes and that they are given choices. One resident gave the example that they were asked what time they would like to go to bed and that their wishes for a changing bedtime are supported by nursing staff. The resident stated nursing staff meet all requests made and that they are very impressed with the care provided. Medical reviews are undertaken at least monthly for all residents. In the seven residents' files reviewed medical reviews were more frequent if any issues or concerns were raised from staff. GPs are available to family/whanau should they have any concerns. This is confirmed in six of six family/whanau interviews.

Short term care plans are used for wound care, infections and other issues that are known not to be long term. Interviews with clinical staff (four RNs and 10 HCAs) confirm their knowledge of all care planning processes and that the care they deliver is guided by the care planning process. Changes to residents' care are discussed at handover as observed on the days of audit.

ARRC requirements are met.

Criterion 1.3.8.2 (HDS(C)S.2008:1.3.8.2)

Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.8.3 (HDS(C)S.2008:1.3.8.3)

Where progress is different from expected, the service responds by initiating changes to the service delivery plan.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.3.12: Medicine Management (HDS(C)S.2008:1.3.12)

Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.

ARC D1.1g; D15.3c; D16.5e.i.2; D18.2; D19.2d ARHSS D1.1g; D15.3g; D16.5i..i.2; D18.2; D19.2d

Attainment and Risk: PA Low
Evidence: There are policies and procedure in place which clearly describe the medicines management system which is implemented by the service. This includes the rights of residents to self-administer medications if they are able. At the time of audit there are no residents who self-administer medications.

All medicines are prescribed by medical practitioners and dispensed in robotic packs by the pharmacy. Administration is undertaken by registered nurse (RN)s or enrolled nurse (EN) and as observed on the day of audit this practice meets all legislative requirements and best practice procedures are demonstrated. All staff who administer medicines have an annual competency test and 17 RN and one EN competencies are sighted in documentation held by the clinical nurse manager. All medicines are securely stored. Staff follow the documented procedure for ensuring all non used or expired medicines are returned to the pharmacy.

A review of 12 of 12 medicine files identifies staff signatures samples are on each file and that medication is signed for when given. Reconciliation process are implemented and include six monthly pharmacy input. Controlled medications are checked by two staff when administered and ongoing weekly checks are documented.

Regular documentation to state that the GP three monthly reviews have been undertaken was not sighted on six of the 12 files reviewed. The standing orders sighted do not have all the information required to meet the MOH guidelines for standing orders. These are areas identified for improvement in criterion 1.3.12.6.

Criterion 1.3.12.1 (HDS(C)S.2008:1.3.12.1)

A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.

Attainment and Risk: FA

Evidence:

Robotics

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.3.12.3 (HDS(C)S.2008:1.3.12.3)

Service providers responsible for medicine management are competent to perform the function for each stage they manage.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.12.5 (HDS(C)S.2008:1.3.12.5)

The facilitation of safe self-administration of medicines by consumers where appropriate.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.12.6 (HDS(C)S.2008:1.3.12.6)

Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.

Attainment and Risk: PA Low

Evidence:

A review of 12 medicine charts was undertaken and identifies that nursing staff record the administration of medicines in an accurate manner. All medicine records have completed signing sheets and staff signing identification. On six of the 12 medication charts reviewed, no documentation could be found to identify that the GP has completed regular three monthly medicine reviews. Monthly medical reviews are documented in seven of seven residents' medical notes but these do not identify if a medicine review has been undertaken.

Standing orders information does not meet all the requirements described in legislation. For example contraindications are not identified. The instructions that are written are fully understood by the four RNs interviewed. (Only RNs and the EN administer medications).

Finding:

Time frames show that three monthly medicine reviews for six of the 12 medication charts reviewed exceed the required three month timeframe. Three charts are four months apart, two are five months apart and one is six months.

Not all aspects of the standing orders sighted meet current legislative requirements.

Corrective Action:

Ensure medicine review timeframes are met and that all instructions on standing orders meet legislative requirements.

Timeframe (days): 180 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.3.13: Nutrition, Safe Food, And Fluid Management (HDS(C)S.2008:1.3.13)

A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.

ARC D1.1a; D15.2b; D19.2c; E3.3f ARHSS D1.1a; D15.2b; D15.2f; D19.2c

Attainment and Risk: FA**Evidence:**

Food, fluid and nutritional needs of residents are provided in line with the menu as approved by a registered dietitian in April 2014. Individual resident likes, dislikes and special diets are clearly identified and the information is available to all kitchen staff.

All residents have a nutritional profile completed upon entry to the service and if there are any concerns the resident is reviewed by the dietitian as required. This is confirmed in the review undertaken in seven of seven residents' files and a specific dietary review has been completed for one resident who requires a diabetic diet. This information is shown in the information sighted in the kitchen.

All food is prepared on site in a well equipped kitchen. Staff have completed recognised safe food qualifications and the kitchen manager holds City and Guild 7061 and 7062. The second in charge cook holds unit standard course 167 and 168.

All aspects of food procurement, production, preparation, storage, delivery and disposal comply with current legislation and guidelines. Food temperatures are taken and measured using Hazard Analysis and Critical Control Point (HACCP) guidelines. Chiller, fridge and freezer temperatures are taken daily and are within safe food storage range.

The service uses a rotation system for the storage of dry foods which ensures older stock is used first. All food is clearly labelled. The kitchen manager stated they have at least 10 days food supplies at all times in case of an emergency.

Interviews with seven of seven residents confirm they are satisfied with the food service. This is supported by a six monthly resident food satisfaction survey results sighted. Only minor issues such as the soup not having enough salt and pepper were noted. Any issues raised are followed up by corrective action planning, such as ensuring there are always condiments on each table.

Criterion 1.3.13.1 (HDS(C)S.2008:1.3.13.1)

Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.

Attainment and Risk: FA**Evidence:**

Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.3.13.2 (HDS(C)S.2008:1.3.13.2)

Consumers who have additional or modified nutritional requirements or special diets have these needs met.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.3.13.5 (HDS(C)S.2008:1.3.13.5)

All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Outcome 1.4: Safe and Appropriate Environment

Services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensures 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.

Standard 1.4.2: Facility Specifications (HDS(C)S.2008:1.4.2)

Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.

ARC D4.1b; D15.1; D15.2a; D15.2e; D15.3; D20.2; D20.3; D20.4; E3.2; E3.3e; E3.4a; E3.4c; E3.4d ARHSS D4.1c; D15.1; D15.2a; D15.2e; D15.2g; D15.3a; D15.3b; D15.3c; D15.3e; D15.3f; D15.3g; D15.3h; D15.3i; D20.2; D20.3; D20.4

Attainment and Risk: FA
Evidence: The sighted building warrant of fitness expires 14 October 2014. There have been no major changes to the service.

NZS 8134.2:2008: Health and Disability Services (Restraint Minimisation and Safe Practice) Standards

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

Standard 2.1.1: Restraint minimisation (HDS(RMSP)S.2008:2.1.1)

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Attainment and Risk: FA
Evidence: The use of enablers is voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining resident independence and safety. The in-service training includes restraint minimisation and safe use (which includes enablers use). Mercy Parklands uses the same assessment, consent, review and monitoring process for restraint and enablers. All 10 HCAs interviewed demonstrate an understanding that the intent of the use of a restraint device (approved restraints are low/low beds, lap belt or bed rail) is either voluntary (as an enabler) or is used to restrict the resident's movement for safety reasons (a restraint).

Criterion 2.1.1.4 (HDS(RMSP)S.2008:2.1.1.4)

The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

NZS 8134.3:2008: Health and Disability Services (Infection Prevention and Control) Standards

Standard 3.5: Surveillance (HDS(IPC)S.2008:3.5)

Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.

Attainment and Risk: FA
Evidence: <p>Mercy Parklands infection control coordinator is contracted and works nine hours per week. Monthly data collected from all areas of the facility are reported to the infection control coordinator who collates the information and evaluates results. This data is also sent to an outside quality performance agency and benchmarked against other like organisations. Data is discussed at the Health Incorporated committee and appropriate corrective actions are put in place as requested. The analysis of data results are shared with staff at meetings as confirmed in meeting minutes sighted. Interviews with staff confirm their knowledge and understanding of their responsibilities related to recording and reporting infections. Seven of seven residents' files reviewed identify residents who present with signs and symptoms of infections are treated according to policy and procedures to meet the requirements of the infection control programme which is in place.</p> <p>Data collection for infection control surveillance meets the requirements of the Health and Disability Services Standards (2008) requirements. Data identifies that the organisation maintains or has a slight reduction in the infections reported over a 12 month period. The infection control coordinator presents regular staff education sessions related to all aspects of infection reduction techniques, including correct positioning when a resident is being fed, in an effort to further reduce chest infections. Educational material is sighted on the day of audit. Bi-annual antimicrobial audits are conducted for each hub of the facility and the GPs are informed of the results.</p>

Criterion 3.5.1 (HDS(IPC)S.2008:3.5.1)

The organisation, through its infection control committee/infection control expert, determines the type of surveillance required and the frequency with which it is undertaken. This shall be appropriate to the size and complexity of the organisation.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 3.5.7 (HDS(IPC)S.2008:3.5.7)

Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)