

Mercy Parklands Limited - Mercy Parklands Hospital and Retirement Home

Introduction

This report records the results of a Certification 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 The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

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

The specifics of this audit included:

Legal entity: Mercy Parklands Limited

Premises audited: Mercy Parklands Hospital and Retirement Home

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: 12 April 2016 End date: 14 April 2016

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 96

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

Indicator	Description	Definition
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

Mercy Parklands is owned by Mercy Healthcare and is located in Auckland. The facility has 97 beds and provides hospital level and rest home care.

There are additional contracts to provide palliative care, orthopaedic interim care and care for younger residents under 65 years. There is also a non-secure home environment within the facility to provide care for residents with cognitive impairment. The organisation has recently achieved accreditation for a third year for their model of care philosophy 'Spark of Life' for which they have recognition as the world's first 'Spark of Life' Centre of Excellence.

The certification audit was conducted against the Health and Disability Service Standards. The audit process included the review of policies and procedures, the review of resident and staff files, observations and interviews with residents, family, management and staff. There are two continuous improvement findings in relation to resident care and one area requiring improvement relating to medication management as a result of this audit.

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.

All standards applicable to this service fully attained with some standards exceeded.

The residents receive services that respects their rights. The staff demonstrated knowledge and awareness of their obligations of consumer rights legislation. The residents are treated with respect, dignity and are not subject to abuse, neglect or discrimination.

The service provides an environment that encourages good practice, which includes evidence-based practice in the implementation of the 'Spark of Life' approach and robust systems for falls minimisation.

Residents and families receive full and frank information and open disclosure from staff. The residents, their families or enduring power of attorneys (EPOAs) are involved in the care planning, decision making and consent processes. Where there is an advance directive, the staff act on its directives.

The mission and values reflect tikanga best practice and practical guidance is available to staff to ensure there are no barriers for Māori. Two staff are te reo Māori speakers, which along with the availability of a whānau room, ensures a welcoming environment for Māori and their whānau. Residents, family members and staff state the facility provides a culturally safe environment for the ethnically diverse backgrounds of residents and staff.

Links with family of all ages was evident and there are no barriers to community involvement by residents.

The complaint management system is transparent and responsive. Residents and relatives interviewed stated they receive information on the system. The central database contains all required and relevant information.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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The governing body provides clear direction and leadership and approves the strategic and annual plan. The organisation has an experienced leader with staff reporting support in decision making and service delivery.

Quality and risk management systems are integrated with a quality plan being implemented. Quality is well embedded and staff report their involvement in corrective action projects and audits. There is a consumer representative on the quality committee and this committee oversees all key service components. The committee meets regularly and minutes were reviewed. Quality and service information is trended and reported to staff and to the board.

Policies support staff in service delivery. These policies are current, comprehensive and reference legislation and good practice. The document control system is effective.

Organisation risks are identified. The register shows they are risk rated and have action plans to address the risk. Formal review of the risk register occurs three monthly or more frequently for risks identified as extreme.

The adverse event system is guided by policy which provides clear support to staff and management on statutory reporting requirements. The central database of adverse events is comprehensive and a review of hard copy forms shows evidence of resolution and corrective actions undertaken to improve service delivery.

The organisation employs appropriately skilled staff to provide clinical and non-clinical care. On appointment professional staff have validation of registration, scope of practice and an annual practicing certificate. Staff report that orientation is comprehensive and helpful. Records are held on personnel files. Ongoing education is provided and training records were reviewed.

Residents and family interviewed reported there are adequate staff to meet their needs. The organisation's clinical master roster identifies volume and skill mix of staff for each shift and this is achieved. The organisation contracts general practitioners who are available to cover all hours. The residents have access to employed allied health providers.

The consumer information system is managed in a timely and accurate way. Each resident has a single record and records are secured privately out of sight of the public.

Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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The entry requirements for hospital and rest home level of care are clearly documented. The service also provides interim care to orthopaedic patients from the DHB, for which there are specialised entry requirements. Residents and families receive accurate information on admission to the service. If entry to the service is declined, a record is maintained and the potential resident and/or their family/whānau referred to a more appropriate service.

The processes for assessment, planning, provision, evaluation, review, and exit are provided within time frames that safely meet the needs of the resident and contractual requirements. The service has implemented the required electronic assessment tool (interRAI). The care plans described the required support and/or intervention to achieve the desired outcomes and reflect the services 'Spark of Life' approach. The evaluation record showed the progress the resident is making towards meeting their goals. Where progress is different from expected, the service responds by initiating changes to the care plan. The service is coordinated in a manner that promotes continuity in service delivery and a team approach to care delivery.

Referral to other health or disability service providers is appropriately facilitated by the general practitioner or registered nurse. There is an appropriate process and risk assessment to facilitate any discharge or transfer to other providers.

The service provides a planned activities programme to develop and maintain skills and interests that are meaningful to the residents, which includes the 'Spark of Life' clubs to engage residents in meaningful ways. There are processes in place for safe medicine management, with the exception of ensuring all medications that are given are signed as administered. Staff responsible for medicine management have been assessed as competent to perform the function for each stage they manage.

Resident's nutritional needs are assessed on admission and reviewed three monthly or more often if a change occurs, such as unexpected weight loss. Interventions are instigated by a registered dietitian and the food service staff implement these as directed. Specific dietary needs including pureed food, supplements and cultural requests are communicated to the food service staff and documented to ensure the residents' needs are met. Residents and family members expressed their satisfaction with the food and fluids provided. Food service staff are appropriately trained in food safety national qualifications and safe food handling practices were observed.

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 facility maintains a safe, clean environment which residents and family members report they feel safe and secure in. The purpose built building is well ventilated, is full of natural light and is well proportioned enabling ease of mobilisation for residents using a variety of mobility aids. There are several comfortable lounges and dining rooms easily accessible to residents and visitors as well as an internal safe courtyard open to the air.

There are adequate toilet and shower facilities many of which are shared, however residents say their privacy is maintained at all times.

Hazards are identified and minimised. Staff are aware of these and use the personal protective equipment supplied as required and follow safe practices to prevent harm to themselves or others. Updated material safety data sheets are available to staff. Emergency and fire procedures are understood by staff and trial evacuations are practiced regularly. Emergency provisions are available.

Restraint minimisation and safe practice

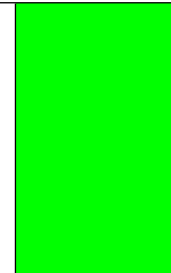
Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The service has a commitment to minimising and appropriate use of restraint/enablers. Restraint and enablers are only used as a last resort to maintain the resident's safety and comfort. Clear definitions in the policies reviewed ensures staff understand the implications of restraint and enabler use. The restraints and enablers used are bed rails, lap belts and low-low beds.

There are appropriate processes in place to ensure that when restraints and enablers are used a sound assessment, review and evaluation process is occurring. The restraint minimisation committee monitors and approves all restraint use. As part of the internal auditing programme and the monthly restraint minimisation committee, there are regular quality reviews of their use of restraint.

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.

There is an experienced appropriately trained infection control nurse accountable for the infection prevention and control programme at the facility, who reports via the service manager to the chief executive officer. The programme is well resourced and is evaluated annually as part of the annual planning cycle. Surveillance data is trended and analysed internally and benchmarked with an external international programme. The usual indicators, such as gastro intestinal, respiratory and urinary tract infections and immunisation rates, are collected.

An audit timetable is followed and improvements made in response to findings. A full suite of policies and procedures which reflect best practice are available to guide staff.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	2	47	0	1	0	0	0
Criteria	2	98	0	1	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is displayed throughout the facility. New residents and families were provided with copies of the Code as part of the admission process. Staff demonstrated knowledge on the Code and its implementation in their day to day practice. Staff were observed to be respecting the residents' rights.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>The residents' files reviewed had consent forms signed by the resident or their next of kin/enduring power of attorney (EPOA). The files contained copies of any advance care planning and the resident's wishes for end of life care. Staff acknowledged the resident's right to make choices based on information presented to them. Residents and family expressed no concerns related to informed consent.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>The residents and family/whānau reported that they were provided with information regarding access to advocacy services. Contact details for the Nationwide Health and Disability Advocacy Service is listed in the resident information booklet. Education on advocacy and support is</p>

		conducted as part of the in-service education programme.
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents, family and visitors interviewed described that the facility staff welcome all residents' visitors warmly and they all feel able to visit whenever they want to. Many visitors of all ages were observed visiting the facility. Residents were pleased to report they have had special family functions onsite with the assistance of the staff.</p> <p>Residents and family members described being supported outside the facility as required. The availability of onsite services such as a; dentist, podiatrist, and hairdresser was seen as a benefit by both residents and their family. The onsite pastoral care and the availability of a chapel was seen as a particular advantage by residents, family and visitors interviewed.</p>
<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>A review of the complaints policy showed it provides clear guidance to staff on managing a complaint. Staff interviewed understood the complaints process and family interviewed stated that they has been provided with information on making complaints as their relative was admitted. This was verbal and written information. The policy and practices comply with the Code of Health and Disability Services Consumer Rights, in particular Right 10. The central database of complaints was reviewed and contains all relevant information.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>The Code is discussed with residents and families as part of the pre-admission and admission processes. A copy of the Code and advocacy brochure and contacts are provided as part of the admission packs and displayed throughout the facility. The residents and families report that they have had plenty of opportunities when the Code is discussed and reinforced (including the monthly community/residents meeting) to become familiar with their rights.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>There is one large room that is currently shared by a married couple, with all other rooms being single rooms. The residents have a privacy sign that they put on their doors that indicates that staff cannot come into their bedroom unless they are invited to enter by the resident.</p> <p>The files reviewed reflected that care is provided that is responsive to the individual cultural and spiritual needs of each resident. The services</p>

		<p>are planned so the residents can maintain as much independence as possible. The relatives reported satisfaction with the care provided and have no concerns about abuse or neglect.</p> <p>Staff demonstrated knowledge on identifying any suspected abuse and know who to report to if they suspect abuse or neglect.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>The mission and values reflect the principles of the Treaty of Waitangi and staff reflected this when interviewed.</p> <p>The Māori Health plan and Death and Tangihanga policies describe ways in which barriers are eliminated. Two staff are proficient in the use of te reo Māori. Documented tikanga best practice is available to guide staff and provides detailed practical advice for culturally appropriate service provision.</p> <p>There is a furnished whānau room and food available for whānau. Staff interviewed described the availability of extra mattresses for whānau to sleep over in the room of a seriously ill or dying resident. Staff described that whānau are encouraged to assist with any cares they wish to be involved with and that whānau wishes are accommodated.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Residents with a variety of cultural practices and ethnic backgrounds are accommodated at the facility. Staff interviewed recognised the need to ensure residents feel safe expressing their own identity and beliefs; this is aided by the diversity in cultural and ethnic backgrounds of the staff. Residents and staff were observed exchanging greetings in their own language. A resource of many different cultural behaviours and practices has been locally collated and is available to guide staff when caring for residents of other cultures. Residents interviewed described their satisfaction with the support available to them.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>The staff individual employment contracts have information on professional boundaries. The orientation and induction programme includes staff education on maintaining professional boundaries. The residents and family/whānau reported they have no concerns about discrimination.</p>
<p>Standard 1.1.8: Good Practice</p>	CI	<p>Evidence-based practice was observed, promoting and encouraging good practice, with the service being recognised as a national and</p>

<p>Consumers receive services of an appropriate standard.</p>		<p>international leader in the implementation of the ‘Spark of Life’ philosophy to dementia care. The service has a robust falls management system, in which the service contributes to a national steering group on their falls minimisation and minimising injuries for their falls bundle of care.</p> <p>Other examples included policies and procedures that are linked to evidence-based practice, regular visits by the GP, links with the local mental health services and palliative care services. There is regular in-service education and staff access external education that is focused on aged care and best practice. This included pressure area prevention in December 2015 and 2016. Staff reported that they were satisfied with the relevance of the education provided. The residents and family/whānau expressed high satisfaction with the care delivered.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>The service promotes an environment that optimises communication through the use of interpreter services as required. Staff education has been provided related to appropriate communication methods. The service has not required access to interpreting services for the residents. Policies and procedures are in place if the interpreter services are needed to be accessed. Documentation of open disclosure following incidents/accidents is evident.</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>The Integrated Business and Quality Plan 2016/2017 articulates the mission and values. Pastoral care is a key performance area. The mission and activities demonstrate these values. The annual strategic planning workshop minutes show that mission and values are reaffirmed.</p> <p>The Chief Executive has professional nursing and business qualifications and has been a senior manager in health services for over 20 years. There is a delegations of authority policy.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>The Chief Executive is supported by an experienced management team and minutes of their meetings show effective team work. Staff report that services run smoothly and they can always get direction on matters relating to their responsibilities. There is a designated deputy for the Chief Executive and staff indicated they are informed of changes in the absence of the chief executive.</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>FA</p>	<p>The quality and risk systems are integrated. Staff interviewed understood the quality priorities and high risks. Staff participate in the management of the quality and risk system.</p> <p>The organisation has a range of policies and procedures to meet the needs of the service. Policies and procedures reviewed were referenced to legislation and regulation and where appropriate good practice. The policy standard states policies will be reviewed at least three yearly and a review of the policy file shows this is occurring and policies are up to date. The document control system is guided by policy and obsolete policies are stored on site. The system for updating and approving policies is able to be explained by both managers and staff and they indicated they are involved in policy reviews and updating.</p> <p>The quality committee oversees all key components of service delivery. Minutes reflect reports from infection control, incidents and complaints, health and safety clinical services and quality improvement projects. Attendees at the quality committee report they have the responsibility of reporting back to staff, recommendations from the committee. Quality improvement data and analysis (e.g., incident trends) are collected. Staff meeting minutes show this information is shared with staff. Staff say they discuss this information and further actions to be taken. The Chief Executive reports to the board show reporting of quality improvement data. Monitoring of achievement against the business, quality and risk plan is ongoing and board minutes show quality updates are received by the board.</p> <p>Corrective actions are identified by staff and from incidents and are formed into an action plan using the project form. A review of this file showed progress on addressing corrective actions. The minutes of the quality meeting record when these projects are completed. Staff interviewed were able to give examples of projects they had been involved in.</p> <p>Risks are identified and placed in the register. The register is monitored by the management team and formally reviewed quarterly or more frequently according to risk rating. On review it is seen that all risks are rated and have action plans in place to manage, minimise or eliminate the risk. Staff interviewed were aware of risks and hazards relevant to their workplace and role.</p>
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<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>FA</p>	<p>The organisation has an adverse event policy and system. Staff interviewed described how they report adverse events using a standard template. Managers outlined investigation processes and the central database was reviewed. The database holds all required information and identifies resolutions and recommendations.</p> <p>Managers were able to outline statutory/regulatory essential notification requirements and could give examples of these.</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>The Chef Executive explained that the organisation budget and workforce plan contains detail of skill mix and resources required to provide services.</p> <p>The organisation is currently recruiting to replace any staff who have recently resigned. On appointment of staff validation of registration, sighting of practising certificates and confirmation of scope of practice occurs. This information was reviewed on personnel files.</p> <p>Comprehensive orientation to the organisation and specific role is given. Written material and resources support this process. Once completed the orientation evidence is held on personnel files. Staff recently appointed indicated that the orientation has been of value.</p> <p>An extensive education calendar is published at the organisation. This is in addition to the three monthly orientation day in which all mandatory training occurs. Training records reviewed showed high levels of attendance at ongoing education sessions. Staff reported that they have the opportunity to identify their learning needs and are able to attend education sessions.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>Annually human resources needs are identified and budgeted. The organisation has a master roster which is the preferred staffing model. This identifies skill mix and staff volumes. The organisation is staffed to this model. Staff interviewed agreed the roster is at preferred levels with replacement staff rostered to cover short notice absences. Medical staff are contracted to provide 24-hour cover. Physiotherapy and occupational therapy staff are employed to meet requirements.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p>	<p>FA</p>	<p>Information is entered on the record at the time of the resident's admission. The records reviewed showed all required and relevant</p>

<p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>		<p>information. Information is stored in hard copy at the 'nurse hub' behind closed doors and is not visible or accessible to visitors. On review records were legible with name and designation of the service provider identifiable. The residents have a single record which showed entries from all service providers.</p>
<p>Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>The service manager oversees entry to the service. The enquiry form records all enquires and if the potential resident has an appropriate assessment for hospital or rest home level of care. The service also provides interim care under a contract with the DHB, and the resident/patients who are admitted under this service are referred by the DHB to meet specific orthopaedic rehabilitation/recuperation requirements. The resident information handbook contains accurate information about the service. All residents' files contained an appropriate needs assessment for rest home or hospital level of care. The service updates any vacancy on the Eldernet website each weekday.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>When admission has been required to the acute care hospital, the service utilised the DHB's transfer form/envelope. The referral process documented any risks associated with each resident's transition, exit, discharge, or transfer. This included expressed concerns of the resident and family/whānau and a copy of any advance directives. Along with the transfer form/envelope, the RNs reported that the service also provides a copy of any other relevant information.</p>
<p>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.</p>	<p>PA Low</p>	<p>The medication management policy provides guidance on medication reconciliation, prescribing, ordering, checking, storage, administration, and documentation of medications. Medications are supplied fortnightly in prepacked sachets for each resident. The standing orders comply with current legislation and best practice.</p> <p>Signing sheets are not fully completed at each medication administration.</p> <p>There were some residents who were self-administering some of their medications at the time of audit (such as eye drops and inhalers). An assessment process and approval from the GP is gained for these residents and there is secure storage in the resident's rooms to facilitate</p>

		<p>safe self-administration. The self-administration is mainly occurring with residents admitted under the interim care services.</p> <p>Staff responsible for medication management have all completed medication competencies and on-going education relating to medication management as verified on the education record spreadsheet reviewed.</p> <p>The service implements reconciliation processes which include the checking of all blister packs for accuracy by the RN when delivered to the facility. There are processes in place to rotate the stored medicines to ensure they do not expire.</p> <p>The GP conducts medicine reconciliation when residents are admitted to the service and at least three monthly thereafter. Medicine file reviews showed that each medication was individually signed.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>Summer and winter menus are designed to accommodate the needs of the resident group in line with nutritional guidelines and are reviewed by an external registered dietitian to ensure this. The dietitian visits monthly to review any residents requiring clinical review. Nutritional profiles are updated three monthly or as a change in need occurs. The clinical staff notify the food service manager with changes as required.</p> <p>Specific cultural dietary needs are identified on admission and these are documented in the initial nutritional assessment.</p> <p>Residents report they are satisfied with the food and fluids provided and if they have a complaint or suggestion this is taken into account and changes are made.</p> <p>Residents' specific dietary requirements are as assessed and recorded in their nutrition profile. This information is passed to the food service staff who prepare appropriate meals and supplements to ensure the residents' needs are met.</p> <p>The Hazard Analysis Critical Control Point (HACCP) food safety management system is followed by the food service staff, most of whom have completed unit standards relevant to their roles. Food, fridge and freezer temperatures are recorded in line with the requirements. Suppliers all follow the HACCP guidelines and their supply truck temperatures are tested by the food service manager on a random ad hoc basis to ensure compliance. Food is dated and colour coded for</p>

		easy recognition to aid appropriate food rotation. A waste disposal unit in the kitchen ensures food scraps are removed efficiently.
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The service manager reported if the service is to decline entry to a potential resident, this is recorded. When entry is declined, the referred, prospective resident and family are informed of the reason why.</p> <p>The admission agreement is developed through an aged care association that is then personalised to the service. The agreement has clauses on the change in level of care process when the service can no longer meet the needs of the resident. As the service provides hospital, rest home and interim care services, residents assessed as requiring secure dementia care, would be referred to a more appropriate secure service that can meet the resident's needs. The service does have a hub that specialises in residents with cognitive impairment, with care implemented under the 'Spark of Life' though this is not a secure dementia service, and if a resident requires secure dementia care, the service requires the transfer of these residents to a secure dementia or psychogeriatric service provider.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>The assessments and reassessments are conducted using the electronic interRAI assessment process and the use of the organisational assessment tools. All aged care residents' files sighted have an initial interRAI assessment. The service also uses their own paper based assessments for additional needs that are identified through the assessment process; this includes behaviour assessments, nutrition, falls, wound assessment, pressure injury risk. There are specific assessment tools related to the 'Spark of Life'. There is a summary of the assessed needs of the resident and these are then documented on the care plan. The files record, and residents/families reported, that the care provided meets the resident's needs.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>The care plans are based on the outcomes from the assessments and the identified needs of the resident. The care plan format includes the resident's specific needs, goals/aims and staff interventions required to address those needs. The care plans are person centred and incorporate the service's 'Spark of Life'. The multidisciplinary team contribute to the development of the care plans. The care plans evidenced family consultation and input into their planning, with resident</p>

		stated goals evidenced in the files reviewed. The residents admitted through the interim care programmes have care plans and/or clinical pathways from the referrer, in which the service implements these plans, as well as developing a care plan using the organisational long term care plan format. The residents and family/whānau reported satisfaction with the care and with specific management of their relative's medical conditions.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	The provision of services and interventions are consistent with meeting the needs of the residents and the 'Spark of Life' philosophy. The resident's records are individualised and personalised to meet the assessed needs of the resident. The care was observed to be flexible and focused on promoting quality of life for the residents. All the residents and family/whānau interviewed reported satisfaction with the care and service delivery.
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	The activities programme has gained a continuous improvement rating as the service provides a planned activities programme to develop and maintain skills and interests that are meaningful to the residents.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Evaluations are conducted at least six monthly and recorded on the care plan. The service has processes in place to use the built in evaluation scores when the service reassesses the resident using the interRAI assessment and records this on their own paper based evaluation record. Care evaluations are conducted for all the residents' needs and recorded how the resident's goals have been met over the past three months. When there are changes in the resident's needs, the service changes the long term care plan to capture these changes. The long term care plans identify the need, interventions and evaluation of the interventions. There are also additional short term plans, such as wound treatment, falls and falls minimisation plans, which capture any short term changes. Wounds are evaluated at each dressing change and at least weekly by the wound committee/team. If the issue then becomes a long term need, these are then recorded and updated on the long term care plan.

<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Each of the residents maintain their own GP if available. The GP arranges for any referral to specialist medical services when it was necessary. The residents' files have appropriate referrals to other health and diagnostic services. There is a dental service that residents can access onsite.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Comprehensive documentation including flow charts, guides staff in safe, compliant management of waste. Staff were observed following the organisation's policies by safely managing waste. Yellow bins are available throughout the facility for the safe disposal of sharps. Rubbish bags are readily available and staff were able to describe their actions when disposing of infectious or hazardous waste. Sanitisers and macerators are maintained in the sluice rooms.</p> <p>Material safety data sheets are close at hand for staff to refer to when working with hazardous substances.</p> <p>The appropriate use of personal protective equipment, such as aprons, three sizes of gloves, and goggles, was described by staff spoken to and was observed in use by housekeeping and caregiving staff.</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 warrant of fitness and all required equipment testing sighted was current. There are processes to ensure testing is performed as required annually or bi-annually.</p> <p>Corridors are wide enough and rooms large enough to enable independence for the residents. Residents were observed mobilising freely and safely throughout the facility using a variety of mobility aids they required including, wheelchairs, walkers, reclining chairs, trollies and beds. The resident rooms are all on one level to minimise the risk of harm from falls.</p> <p>Family and residents referred to a large open courtyard that is centrally located as a wonderful environment. The area is flat and easily accessible from several of the four lounges and dining rooms. Shade sails provide shade protection.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing</p>	FA	<p>All residents' rooms have an accessible toilet and hand basin, some share this with the adjoining room. Residents reported they are happy to</p>

<p>facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>		<p>share. The showers are a short distance from each room and are also shared. There are an adequate number of showers and a spa bath which is popular for use by residents. Five residents' rooms have showers as well as toilets. Hot water temperatures are tested and recorded monthly to ensure compliance with safe temperature requirements. Residents describe their satisfaction with the facilities and that their privacy is protected whilst using them.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>The size of the residents' rooms was observed as enabling residents and their visitors to mobilise freely with the use of a range of mobility aids including wheelchairs, walkers, and reclining chairs.</p> <p>The size of the rooms also enabled collections of personal furniture and furnishings whilst ensuring safety of movement around the room. Residents expressed their satisfaction with the size of their rooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Residents and their visitors have the choice of four generously proportioned lounges, four dining rooms, the whānau room, the chapel, the central courtyard and smaller courtyard. Residents and family expressed their satisfaction with the spaces available to them and were observed enjoying these.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>Cleaning products are provided by a well-known external contracted service which does a monthly inspection to monitor the effectiveness of the service. Education sessions to staff are also provided as part of the contract. Each resident's room is cleaned daily and extra 'spring' cleaning is done in each room monthly on a schedule. Audits are performed regularly to ensure cleaning is safe and hygienic.</p> <p>Housekeeping staff have two locked chemical storage areas which were observed as being clean, tidy and locked, only accessible by them.</p> <p>The laundry service is contracted to an external provider. Residents reported their satisfaction with the cleaning and laundry service.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>Staff report they are trained in emergencies and were able to describe appropriate emergency responses as documented in the facility's staff instructions. Recent fire alarm activations provided the opportunity for practice in responding to a fire emergency. Fire extinguishers are</p>

		<p>available throughout the building and a fire blanket is available in the kitchen. An emergency manual describes the responses to other relevant emergencies such as earthquakes and hold ups.</p> <p>There is an approved evacuation plan. The facility has fire sprinklers throughout, smoke detectors, and smoke stop doors, which were observed operating correctly during testing by the external contracted service. First aid kits are available in the kitchen and the store room.</p> <p>Gas cooking is available in the kitchen from a stand-alone system. There are two hours of alternative lighting available and hands-free headlight torches. Water is available from water storage tanks on the adjoining property. Emergency stock is stored securely and rotated annually.</p> <p>The facility's call bell system includes emergency bells and movement sensor alarms. There are call bells in all residents' rooms, toilets, showers, halls, dining rooms and lounges.</p> <p>The reception area is manned during usual business hours and all visitors and contractors' onsite are given a sticky name badge to wear so they are recognisable by staff. Staff are comfortable challenging people they do not recognise. The facility is secured from 8pm until 6am the next day by the nursing staff who follow a security night check procedure. There is a security roster indicating which team leader is responsible for the security check. The team leader signs to indicate the check has been completed. External doors are monitored and include outwards facing security cameras at the front entrance and inwards goods area. A security contractor does overnight onsite surveillance during the night. A resident reported seeing the security staff at least once each night.</p> <p>Families are encouraged to report alleged loss or theft of resident's belongings to the Police if following an internal investigation onsite these are not recovered. Keys are kept securely and regular audits are done to ensure they are all accounted for.</p> <p>Residents, family and staff say they feel safe and secure.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe</p>	<p>FA</p>	<p>The building was purpose built with electric heating and an abundance of natural light throughout the facility. All residents' rooms have opening</p>

<p>ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>		<p>windows of large proportions with natural light from these. The lounges and dining rooms open through full height glass doors onto the central courtyard. The staff room is well appointed with natural light, opening windows and is heated appropriately.</p> <p>Residents, family and staff report they are comfortable and enjoy their surroundings.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>There is an infection control nurse who is accountable for minimising the risk to residents and staff from infection, and who has clear reporting lines via the service manager to the chief executive officer. The infection control nurse reports monthly to the service manager and to the Health Incorporated meeting. Infection control issues are reported through to the management meeting and to the board by the chief executive officer, as required.</p> <p>Staff stated all staff take responsibility for maintaining a clean infection free environment.</p> <p>Monthly walk around audits are done by the infection control nurse and the resulting corrective actions are completed by the relevant staff and managers.</p> <p>The infection control nurse is involved in the evaluation of trial equipment. The service manager reports doing regular research and resourcing of equipment and furniture coverings that are fit for purpose and enable easy cleaning.</p> <p>The infection control programme is a comprehensive plan of infection prevention activities, including but not limited to; education, infection prevention, audit, benchmarking, and surveillance. The programme is reviewed annually as part of the quality meeting which incorporates all aspects of health and safety, quality and wellness.</p> <p>There is an outbreak policy and outbreak kit which is used when an outbreak is suspected to ensure any infection is contained. Staff, residents and family described a recent occasion when this was followed. Every effort was made to minimise exposure to others and the district health board was notified. Staff reported they were advised to stay away from work until they were well and not infectious, which they did. Family members said they were aware of the suspected outbreak</p>

		and were kept informed via email.
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The infection control nurse is an enrolled nurse with a certificate in infection control who attends national conferences in alternate years, and maintains links to New Zealand Nurses' Organisation speciality group via the national committee website, attends local regional meetings, and gets advice from the district health board experts and the Ministry of Health via their website.</p> <p>There are two infection control link staff who champion infection prevention practice onsite. Staff report they are well supported by the infection control nurse who they can contact out of usual business hours if the need arises for advice. The infection control nurse in turn accesses the local district health board experts for advice as required.</p> <p>Every resident's bedroom, bathroom, toilet and the dining room has hand washing facilities and/or alcohol hand rub available.</p> <p>Information resources are readily available to residents and staff. The residents say their needs are well met.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>There is a full suite of infection prevention and control policies and procedures which reflect standard precaution practices and relevant legislation. Staff are trained in their use from the commencement of employment as they relate to their working areas. Staff reported these are readily available to them in each of the nurses' work stations and are easy to implement.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection control nurse is an enrolled nurse with many years of experience in the role. Infection control education commences for all staff on employment to the facility. The infection control nurse reports regular ad hoc training is provided at handover when the opportunity arises in addition to a regular training programme. The training is done as part of the annual update which all staff must attend and following any audit findings which indicate specific education is required. Infection control topics are included in the toolbox education sessions provided monthly to staff throughout the facility. Staff were observed following correct infection prevention and control practices.</p>

		Residents interviewed were able to describe that they were given infection control and prevention education in a manner that they understood. Staff report they record these conversations in the resident's record when they occur. Family and some residents with email access receive alert emails with a suspected or actual outbreak. Family members interviewed understood the need to wash and dry their hands or use the alcohol hand rub provided, to perform safe coughing etiquette and to refrain from visiting if they are infectious themselves.
<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>	FA	<p>The infection prevention and control programme describes the surveillance activities which are performed throughout the year. The programme is evaluated each year against the objectives, priorities and methods used.</p> <p>The facility provides quarterly benchmarking data to an external Australasian quality monitoring service on infection rates. The indicators for surveillance data are recommended by the infection control nurse and agreed by the health incorporated group. Recommendations are provided by the international bench marking organisation and these are evaluated at the various meetings attended by the infection control nurse and outcomes actioned as agreed.</p> <p>The infection control nurse proactively reviews and analyses all antimicrobial prescriptions, compared with the microbiological results received and the affected residents' signs and symptoms. Surveillance findings are reported to the registered nurses and caregiving staff caring for each of the resident's involved and improvements identified and actioned when necessary.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service currently has 17 residents with restraint use (bed rail and/or lap belt and low-low beds). The service's internal review of restraint use and external benchmarking results record the service has actively minimised the use of restraint over the past four years.</p> <p>Policy clearly identified that enabler use is voluntary and the least restrictive option to maintain the resident's independence and safety. In the files reviewed with enabler use, the enabler is recorded as voluntary.</p> <p>Staff demonstrated good knowledge regarding restraint, enablers and use of de-escalation techniques. All staff were trained/educated</p>

		regarding the restraint policy and procedures as well as managing challenging behaviours and restraint competency were sighted in all care staff files reviewed.
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>In each of the hubs there is a RN or HCA that is the designated restraint coordinator. There is also a RN who is the delegated restraint coordinator for the whole service, with relevant authorities and responsibilities. There was a signed restraint coordinator job description. There is a monthly restraint approval group/quality review committee that is established headed by the restraint coordinator. Restraint decisions were in collaboration with the GP, resident and families. The restraint coordinators interviewed demonstrated knowledgeable about the restraint process.</p> <p>There is a restraint approval committee that meets monthly. The restraint coordinator and restraint committee have approved all restraint use. Consent from family/whānau, GP and a restraint coordinator is required before restraint is approved. In the event of emergency use of restraint, two RNs can make the discussion to use restraint, and then within 24 hours a restraint coordinator will review this. The consent form and approval process was sighted in the files reviewed of residents with restraint use.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>The service has a restraint assessment form that includes the factors of this standard. The restraint coordinators reported that restraint is only put in place following appropriate review of the risks and benefits of restraint or enabler use, such as considering the wellbeing of the resident or others, cultural safety, emotional trauma, physical safety, mobility, will it reduce risk of falls or harm and is there a balance between independence and protection. The assessment process was sighted in the resident files. The 'Spark of Life' approach is also a considering factor in the use of restraint, and restraint is minimised and removed to meet the safety and emotional needs of the resident. Care staff demonstrated, understood and implements alternatives to restraint, such as low beds and sensor mats, whenever possible.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The restraint coordinators reported that restraint is only applied after consideration is given to all possible alternatives and that it will be used with the least amount of force. Restraint is monitored according to risk.</p>

		Frequent falls from bed by individual residents will often generate the commencement of reviewing the need for bed rails. The restraint register documented all restraint and enablers in use. The restraint register records the type of restraint, when approved, review dates and if the restraint is still recommended for use. The register records that the service has reduced the numbers of residents with restraint use.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The evaluation process included all the points in this standard. The restraint coordinators reported that all restraint and enabler use is evaluated at least monthly as part of the restraint committee and three monthly as part of the resident review process. When restraint is initially implemented, there has been a review and evaluation of its appropriateness and effectiveness at the time of restraint use. The evaluation process was sighted in the files of residents with restraint use. The resident and family/whānau consultation and evaluation was evidenced in the files of the residents with restraint use.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The monthly restraint approval committee monitors and reviews the restraint and enabler use for the service. As part of the internal auditing system, an annual review of the restraint processes is conducted. Restraint use is closely linked to the falls reduction programme and the 'Spark of Life' approach. All restraints are used for the safety and comfort of the resident.

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 1.3.12.6</p> <p>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.</p>	PA Low	<p>The medication records reviewed are dated, signed off and signatures can be verified with the specimen signature list. Photo-identification was observed on each record sighted. Allergies and sensitivity are documented on signing sheets. Signature specimen lists are in the front of each medication folder for the medical and nursing staff for verification if required. Six of the medication signing sheets sighted had blank spaces where the staff member is required to sign when they have administered the medications. It was not recorded if the medications were given or if the medication was not given, the reason for this.</p>	<p>Six of the 20 medications signing sheets sighted were not fully completed for each medication administration.</p>	<p>Ensure all medications that are given are recorded as given or record the reason the medication was not given.</p> <p>90 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>Mercy Parklands is the first ‘Spark of Life’ Centre for Excellence and has maintained their ongoing achievement as a centre of excellence for the past three years. Mercy Parklands is continuing to report positive outcomes for residents with dementia, their family/whānau and staff through the implementation of the ‘Spark of Life’ programme.</p> <p>Mercy Parklands falls management programme is overseen by the Allied Health Manager who is an occupational therapist, and is a member of the DHB steering group and cluster group model which has reduced falls and falls with harm as one of the key outcomes. A wide range of initiatives have been put in place under this role. Since the 2009 development of a falls prevention programme at Mercy Parklands, there has been a decrease in the fall median incidence. In 2015 a 58% decrease</p>	<p>The achievement of the implementing the ‘Spark of Life’ and falls minimisation programmes are rated beyond the expected full attainment. The service is the world first Centre of Excellence for ‘Spark of Life’ and have maintained these requirements for three years. The service is contributing to national direction with falls prevention and minimising harm from falls. With the ‘Spark of Life’ and falls minimisation projects there has been a documented review process which includes the analysis and reporting of findings. The projects include documenting actions to make improvements in the education programme, increase staff knowledge, and confidence and skill in caring for the resident’s. Positive outcomes have been measured in staff, resident and relative satisfaction.</p>

		<p>from 2014 falls with serious harm incidence was achieved, demonstrating the overall effectiveness of the programme. To support the effective implementation of the falls prevention programme Mercy Parklands have developed policies and procedures from evidence based practice. This includes a risk assessment and checklist to guide care planning, individual profiling for residents at high risk of falls, information brochures on falls prevention and protective equipment.</p> <p>The service is committed to educating staff in falls prevention and management strategies, providing new staff with an orientation to the service, ongoing educational support, and has an active team of falls preceptors who are responsible for being role models. The service undertakes a thorough internal monthly and annual evaluation of data to ensure continuous quality improvement and inform future practice. External bench marking is completed monthly through ADHB and quarterly through an international benchmarking service. Mercy Parklands has presented their programme outcomes at regional learning sessions and through an educational DVD through the Health, Quality and Safety Commission, and have shared their developed resources and knowledge with other organisations. Results are shared with Mercy Parklands staff in clinical risk meetings and in multidisciplinary meetings.</p>	
<p>Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that</p>	CI	<p>There is a full range of social activities that are available on the weekly programme for all residents to participate in. 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</p>	<p>The achievement of the quality improvement projects in activities programmes and implementation of the 'Spark of Life' clubs is rated beyond the expected full attainment. With these projects there has been a documented review process which includes the analysis and reporting of findings. The introducing of new club activities</p>

<p>are meaningful to the consumer.</p>		<p>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, Art and Gardening clubs. All these clubs evidenced documented evaluations on the resident's participation and the outcomes that residents are achieving from these. With the evaluation of existing clubs, the service has implemented further clubs to provide further meaningful activities for residents who needs are no longer met in previous club memberships. The service provides a documented evaluation and self-assessment on the 'Spark of Life' clubs as part of maintaining their ongoing compliance with evidencing that the service is a centre of excellence for the implementation of the 'Spark of Life' philosophy.</p>	<p>and the evaluation of existing clubs include documenting actions to make improvements in the activities programme. With this there has been increased staff knowledge, and confidence and skill in resident self-worth and developing and increasing resident's skills and participation in meaning activities. Positive outcomes have been measured in staff, resident and relative satisfaction.</p>
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End of the report.