

Mercy Parklands Limited - Mercy Parklands Hospital and Retirement Home

Introduction

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

The audit has been conducted by 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: 1 August 2018 End date: 2 August 2018

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: 92



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

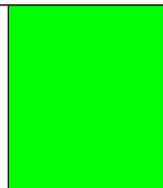
Mercy Parklands Hospital and Retirement Home (Mercy Parklands) provides rest home care, hospital level care and residential disability services (physical) for up to 97 residents. The service is operated by Mercy Parklands Limited, which is owned by Mercy Healthcare, and managed by a chief executive officer. The service operates using the 'Spark of Life' philosophy, particularly focused around residents living with dementia. Clinical oversight is provided by an operations manager, who is also a Spark of Life master practitioner. In February 2018, Mercy Parklands achieved recertification as a 'Spark of Life' Centre of Excellence. Residents and families spoke positively about the care provided. There have been no significant changes to the service and facilities since the previous audit.

This surveillance audit was conducted against a sub-set of the Health and Disability Services Standards and the service's contract with the Auckland District Health Board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, managers, staff and a general practitioner.

This audit has identified three areas requiring improvement related to approval of the winter menu, a current food plan and infection surveillance data analysis. Improvements have been made to the one area requiring improvement at the previous audit around medicines management.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.



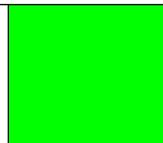
Standards applicable to this service fully attained.

Open communication between staff, residents and families is promoted and was confirmed to be effective. There is access to interpreting services if required.

A complaints register is maintained with complaints resolved promptly and effectively. The one previous Health and Disability Commissioner complaint has been closed with all recommendations addressed.

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.

Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body is regular and effective. An experienced and suitably qualified person manages the facility.

The quality and risk management system include collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved, and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and were current and reviewed regularly.

The appointment, orientation and management of staff are based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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Residents' needs are assessed by the multidisciplinary team on admission within the required timeframes. Registered nurses are on duty 24 hours each day in the facility and are supported by healthcare assistants, a range of allied health staff and designated general practitioners.

Care plans are individualised, based on a comprehensive and contain an integrated range of clinical information. Short term care plans are developed to manage any new problems that might arise. All residents' files reviewed demonstrate that needs, goals and outcomes are identified and reviewed on a regular basis. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard. The 'Spark of Life' philosophy is well embedded into residents' documentation and service delivery processes.

The planned activity programme, overseen by a team of diversional therapists, assistants and volunteers, provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are managed according to policies and procedures based on current good practice and consistently implemented using an electronic system. Medications are administered by registered nurses, all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Protocols guide food service delivery with a food safety plan currently with the local council. The kitchen was well organised and clean. Residents verified satisfaction with meals.

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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There is a current building warrant of fitness. There have been no changes to the building since the previous audit.

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 organisation has implemented policies and procedures that support the minimisation of restraint. There were five enablers and five restraints in use at the time of audit. A comprehensive assessment, approval and monitoring process with regular reviews occurs. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

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.		Some standards applicable to this service partially attained and of low risk.
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Implementation of the infection prevention and control programme is led by an experienced and appropriately trained infection control coordinator.

Aged care specific infection surveillance is undertaken with basic analysis of the data being reported through all levels of the organisation.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	14	0	2	0	0	0
Criteria	0	35	0	3	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 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The complaints policy and associated flow chart meet the requirements of Right 10 of the Code of Health and Disability Services Consumers Rights (the Code). Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so.</p> <p>The complaints register reviewed showed that seven complaints have been received to date for 2018. Complaints are categorised to identify any trends and graphs reviewed of data since 2010 show a relatively stable pattern. A sample of complaints was reviewed, including a concern raised by the Auckland DHB and a complaint received via the Health and Disability Commissioner (HDC). This demonstrated that actions taken, through to an agreed resolution, are documented and completed within the timeframes required by the Code. Action plans showed any required follow up and improvements have been made. Data on timeliness of complaint resolution is tracked and recorded and this showed that, on average complaints are resolved and closed within 14.86 days, with reasons for delays noted and valid.</p> <p>Staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p> <p>The Ministry requested follow-up against aspects of a complaint received and investigated by the HDC. This was reviewed by both the clinical and lead auditor and demonstrated that all areas for improvement/requirements have been addressed. A letter signed off by the HDC dated 14 July 2018 notes that the requirements have been met and that no further follow-up is required. A log of all actions and communication with the complainant has been maintained.</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>Residents and family members stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed and the incident management process. In response to a complaint received via the Health and Disability Commissioner (HDC) the service has been focused on improving communication, especially in relation to end of life care. This is also stated as a goal within strategic and operational planning. There has been an increase in the number of residents with end of life care plans over the past year improving communication and expectations in relation to end of life requirements. Registered nurses have been provided with additional training on communication, including communication related to end of life care. Documentation reviewed showed that only one of the seven complaints received to date in 2018 related to communication. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff knew how to access interpreter services, although reported this was rarely required due to broad cultural mix of staff, relatives and volunteers to support residents with communication. There are residents who have communication difficulties or are 'non-verbal' and staff support these residents with the use of charts, pictures, and a white board. The Spark of Life training covers non-verbal communication skills.</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 2018-2019 was reviewed and discussed with the operations manager. This planned is reviewed yearly with documentation around objectives achieved and identification of new objectives. The mission, vision values, and 'motto' are defined and displayed around the organisation. The plan described annual objectives and the associated actions and measures. A sample of bi-monthly reports to the board of directors/owners showed adequate information to monitor performance is reported. The chief executive of Mercy Healthcare interviewed, who reports to the Board of Directors for Mercy Healthcare Auckland, reported that information provided by the chief executive of Mercy Parklands meets the requirements of the directors and includes financial performance and emerging risks and issues.</p> <p>Mercy Parklands is managed by a chief executive (CE) who holds relevant qualifications and has been in the role since 2001. The CE was not on site during the two days of this audit. The CE is on the board of the NZ Aged Care Association and the Palliative Care Steering Group and maintains knowledge of the sector, regulatory and reporting requirements. The operations manager interviewed, who is from an occupational therapy background is involved with a number of national and regional projects, panels and steering groups, including an expert reference panel for pressure injuries. The clinical manager (a registered nurse with a current annual practising certificate (APC)) oversees the day to day clinical care. Job descriptions for the key leadership roles were reviewed and define responsibilities and accountabilities.</p> <p>The service holds contracts with the DHB for hospital care (medical and geriatric), rest home care and residential</p>

		<p>disability services (physical). The service also provides palliative care and has an interim care contract with the DHB for residents to stay for a short period for 'non-weight bearing' or monitoring. Ministry of Health funding supports younger persons with a disability (YPD) and funding is also provided by ACC for residents, from time to time. At the time of audit, there were 81 residents receiving hospital level care (including two ACC residents), five residents under the interim care contract, four YPD residents and one resident receiving rest home level care. There is also a non-secure home environment within the facility to provide care for residents living with dementia.</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 Integrated Business and Quality Plan provides direction for quality improvement activity and reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, a regular patient satisfaction survey, monitoring of outcomes, clinical incidents including infections and projects. The review of the 2017 plan notes achievements for that year related to the establishment of an audit committee, upgrade to one of the five 'hubs' (that is, Hub 2 where residents with dementia live in a small home like environment), progress with the 'No one dies alone' project and policy and procedure integration. A focus on increasing the 'voice' of the residents/families and communication about their 'end of life' is a focus for the 2018 year.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the management team meetings, quality meetings and staff meetings. Staff reported their involvement in quality and risk management activities through audit activities, improvements projects, staff meetings, planning activities and key portfolio roles. Mercy Parklands is part of the 'QPS Benchmarking' Programme and the operations manager provided examples of the value of review and discussion of data provided related to the 14 indicators. Quality and portfolio dashboards are developed and well displayed around the facility. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually and used to identify the top 10 areas where improvements can be made. These are displayed for staff, residents and families to review and actions are followed up. Residents also provide monthly input at 'community meetings' where a Spark of Life format is followed. The family representative interviewed expressed satisfaction with the level of communication and input provided by residents and families to the services and facilities.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies were based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The operations manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The current risk register and hazard/risk register was reviewed and demonstrated a thorough process around mitigation strategies, review and monitoring, including for health and safety requirements. The CE for Mercy Healthcare reported that risks are reported, reviewed and discussed at the</p>

		board meetings and provided examples of those risks most relevant to Mercy Parklands.
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to the quality, staff, management and health and safety meetings (as applicable). A structured approach is used to investigate events using a 'SOAP' (subjective, objective, assessment, Plan) format, in most cases by the team leader of the 'Hub' where the incident occurred. Several examples of a 'reflective practice' process by the staff involved were also sighted. In all eight examples reviewed there was notation made to indicate that the family/enduring power of attorney (EPOA) has been informed of the incident. Incidents are categorised, and trends are identified and displayed.</p> <p>The operation manager described essential notification reporting requirements, including for pressure injuries. These requirements are defined in policy. One example of a death following a choking event was discussed, along with documentation. This was discussed with the coroner by the doctor and advice was sought from the DHB and Ministry. This was not required to be formally reported/investigated by the coroner. One infection outbreak in late 2017 was report to the public health services and two pressure injuries have been reported (January and February 2017).</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>	FA	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained. Around 100 volunteers ae used in the service to support staff roles (eg, as a 'companion', to read the newspaper, to assist activities staff). The process reviewed to recruit, orientate, and maintain ongoing skills, demonstrated a thorough safe process and completion of records for each person.</p> <p>Staff orientation ('onboarding') includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role and that they are supported by a preceptor throughout the orientation period. Staff records reviewed show documentation of completed orientation, with minor exceptions. Performance reviews were current for all staff, with three in progress, after a three-month period and then annually. The completion of all training requirements is reviewed as part of the performance appraisal process.</p> <p>Continuing education is planned annually, including mandatory training requirements, by the clinical support coordinator in consultation with the clinical manager and operations manager. All staff are required to attend the 'Spark of Life programme training. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. Nearly 90 percent of staff have either level 3 of 4 qualifications on the NZQA framework. Staff reported feeling well supported</p>

		to attend training and complete qualifications. For some spoken with this, had included leadership training and palliative care training. There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The interRAI data is used to support staffing rostering decisions and the facility adjusts staffing levels to meet the changing needs of residents. Staffing is based around the specific requirements of the residents within each 'Hub' and aim to provide continuity of care for the residents who live in each of the five Hubs/homes. Each hub has a team leader/RN. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. They reported a team approach and support to assist any area that may be experiencing a busier period. Residents and families interviewed supported this. Observations and review of a two-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. There is 24/7 RN coverage across the service, with all RNs current in CPR and due to attend again in August. Allied staff/activities staff who take residents off site have completed training in first aid (sighted). Additional support is also provided as needed by the pastoral care team (eg, supporting families during the death of a resident).</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care and the use of the electronic system, Medi-Map.</p> <p>A safe system for medicine management including administration was observed on both days of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. Currently only registered nurses administer medicines and all staff who do this are competent to perform the function they manage. Records were checked to confirm this.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by a registered nurse on the night shift against the prescription and records of these were consistent. All medications sighted were within current use by dates. Clinical pharmacist input is provided.</p> <p>Controlled drugs are stored securely in accordance with requirements in two areas of the facility. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries. The pharmacy checks the controlled drug registers when they bring new stock to the facility and remove unused medicines.</p> <p>The records of temperatures for the medicine fridge were within the recommended range.</p>

		<p>Good prescribing practices were noted within the electronic system. The prescriber was identifiable, all entries and discontinuations were dated, allergies and medicine intolerances were noted and all requirements for pro re nata (PRN) medicines were described. The monthly GP review of medicines that is occurring was evident in the medicine records.</p> <p>There are no residents who self-administer medications in this facility at the time of audit. For safety reasons this is generally discouraged, although appropriate processes are in place to ensure this is managed safely should it be undertaken.</p> <p>Medication errors are reported through the accident/incident reporting system. The resident and/or the designated representative are advised. There is a process within the quality management system for comprehensive analysis of any medication errors, and compliance with this process was verified. There has been a reported decrease in the number of these; however, one was observed during the audit. The appropriate reporting and investigation process was followed through by the clinical manager.</p> <p>Standing orders are used, are current and comply with guidelines. Verbal orders are no longer required due to the use of the electronic system.</p> <p>A corrective action raised during the certification audit in relation to administered medications not all being signed, and medication records not being complete, has been closed as there was no evidence of these issues during the review of 22 resident's medication records.</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>PA Low</p>	<p>The food service is provided on site by a qualified chef, cook and kitchen team. The menu follows summer and winter patterns; however, the current winter menu has not been reviewed by a dietitian to ensure it follows the recommended guidelines for people being supported in a residential aged care facility and this requires corrective action.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. Any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Records of these were reviewed both in residents' files reviewed and in the kitchen. One person with special dietary needs has daily conversations with the cooks to ensure these are adequately met. Although the residents in the dementia service are not in a specialised secure dementia unit there is access to additional food and fluids within the hub over 24 hours, seven days a week.</p> <p>There is adequate documentation that describes safe practices that comply with current legislation and guidelines around all aspects of food procurement, production, preparation, storage, transportation, delivery and disposal. Although a food plan has been developed, this has not yet been registered and approved by the local council, as noted in the corrective action in criterion 1.3.13.5. Food temperatures, including for high risk items, are monitored appropriately. Kitchen staff have undertaken relevant safe food handling training, as have kitchen assistants. It was observed that some have had these qualifications for some time and updates had been internal refreshers from the</p>

		<p>chef.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There is sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed. No complaints about the food were heard and residents informed they get a choice if they do not like a specific food.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. Feedback provided by relatives and residents regarding the level of care was all positive and many accolades were presented. There was evidence that the principles and practices around the Spark of Life philosophy and the falls prevention project, which gained the service provider an acknowledgement of continuous improvement (under criterion 1.1.8.1 Good Practice) in the certification audit, are being upheld.</p> <p>The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. There was also evidence that the different levels of needs were being addressed according to contractual requirements with an example being the strong focus on rehabilitation processes for people on the interim care contract. Similarly, people with dementia are receiving a high level of care and support in a safe manner without being in a locked environment.</p> <p>The GP interviewed, verified that medical input is sought in a timely manner, medical orders are followed, and care is some of the best available. During interview, the manager described ways in which the Spark of Life philosophy has meant staff now see past the disability or behaviour for example and see the whole person, which has resulted in reduced incidents and higher levels of care and support. Caregivers confirmed that they provide care according to the care plans, information provided at handovers and anything else the registered nurses may ask them to do. A range of equipment and resources are available, suited to the level of care provided and in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their</p>	FA	<p>The activities programme is provided by three trained diversional therapists holding the National Certificate in Diversional Therapy, three part time activities assistants and a team of volunteers. One of the assistants is a specialist in 'Spark of Life' therapies.</p> <p>A personal profile in the format of a 'Map of Life' was evident in the residents' files reviewed. These are developed for each person following the completion of a social assessment and personal history undertaken with the resident and/or family/whānau at the time of admission. The assessments ascertain residents' needs, interests, abilities and social requirements and contribute to the activities section of the long-term care plan. The resident's activity needs are evaluated three and six monthly as part of the formal care plan review processes.</p>

<p>needs, age, culture, and the setting of the service.</p>		<p>The planned weekly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities provided reflected residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Examples included outings, both internal and external entertainment, clubs for members who qualify, music and movement, noodle hockey, board games, quizzes and church services and mass. Residents with dementia were observed to be given additional one on one time, while day to day activities such as pikelet making was also occurring. Residents have access to aviary birds and pet rabbits, which they get to handle under supervision. Different activities may be occurring in the different hubs at the same time.</p> <p>During interview, the activities coordinator described how 'Spark of Life' is embedded into everything they do. The activities programme is discussed at the minuted residents' and indicated residents' input is sought and responded to. Resident and family satisfaction surveys demonstrated satisfaction with the programme and that information is used to improve the range of activities offered. Residents interviewed confirmed there is a lot that happens, and they can choose what they want to attend. Reviews of the activities programme are ongoing to ensure the activities programme continues to be meaningful to the residents.</p> <p>The areas of excellence that enabled the service provider to gain a continuous improvement at the previous certification audit are being maintained.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Resident care is evaluated and reported in the progress notes at least once daily, and as needed when a change occurs. If any change is noted, it is reported to the registered nurse. There was evidence of use of the SOAPE tool to assist in writing progress notes for some of the residents requiring more complex care.</p> <p>Care plan reviews are undertaken every three months. Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment or as residents' needs change. Changes are made to the long-term care plan when progress is different from that expected and according to the outcomes in the interRAI assessment summary. Evaluations are documented by the registered nurses.</p> <p>Examples of short term care plans being consistently reviewed for wounds, skin tears, urinary tract infections and changes in weight were viewed. Progress is evaluated as clinically indicated and according to the degree of risk noted during the assessment process and the healing/recovery time. Progress against activity goals are reviewed alongside those for the wider care plan. The activities staff document into dedicated progress notes when indicated. Allied health team reports were also sighted within service delivery plans and GP reviews are occurring monthly for all residents.</p> <p>Family members are invited to the six monthly multi-disciplinary review meetings. Residents and families/whānau interviewed provided examples of their involvement in the evaluation of progress and any resulting changes.</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>	<p>FA</p>	<p>A current building warrant of fitness (Expiry 14 October 2019) was displayed.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>PA Low</p>	<p>An interview was undertaken with the infection control coordinator, who has responsibility for the surveillance of infections. Infection surveillance is referenced within the wider organisational health and safety plan, otherwise known as the health incorporated plan. One of the six goals within the health incorporated plan includes that infection surveillance will be undertaken to achieve a reduction in the incidence of infections. There is reporting criteria for a range of wound and skin infections; urinary tract infections; respiratory tract; eye, ear, nose and throat; gastro-intestinal tract and systemic infections; however, there is not currently a documented process to describe how infection surveillance is expected to occur.</p> <p>Infection surveillance is being completed monthly with graphs providing some information. Meeting minutes show that the number and type of infections is being reported at the health incorporated section of the quality meetings, although this information was not evident in the meeting minutes. There was a lack of evidence to demonstrate that the related numerical data is being reviewed and analysed to contribute to quality improvement processes. These factors, along with the lack of a description of the infection surveillance process have been raised for corrective action. The infection control coordinator informed that any incidence of infections is discussed with the team leader of each hub.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and his role and responsibilities. Restraint is closely linked with the falls prevention programme and restraint use is reviewed as part of this programme for each of the five Hubs.</p> <p>On the day of audit, five residents were using restraints and five residents were using enablers, which were the least restrictive and used voluntarily at their request. A similar process is followed for the use of enablers as is used for restraints.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the</p>

		restraint approval group minutes, files reviewed, and from interviews with staff.
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Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.13.1</p> <p>Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.</p>	PA Low	<p>The winter menu is currently in place for the provision of residents' meals. A copy of a menu review report of the summer menu for 2017 - 2019 from a dietitian was provided; however, the last review of a winter menu for this facility was for 2015 and is no longer current. The chef confirmed the winter menu has had some changes made to it since this timeframe.</p>	<p>The current winter menu has not undergone review and approval by a dietitian to ensure the food, fluid and nutritional needs of residents are provided in line with recognised nutritional guidelines for aged care services.</p>	<p>The menu is reviewed by an appropriately qualified person, such as a dietitian, to confirm it is in line with recognised nutritional guidelines appropriate for residents in an aged care service.</p> <p>180 days</p>

<p>Criterion 1.3.13.5</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.</p>	<p>PA Low</p>	<p>Protocols and procedures are in place for all aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal to ensure compliance with current legislation, and guidelines. Attached to these are recording forms for kitchen cleaning schedules, hot food temperatures, fridge and freezer temperatures and the checking of chilled and frozen food on entry to the facility. The chef informed that documentation associated with the food control plan had been forwarded to the local council. An email response dated June 2018 requested additional information and informed the council had a backlog and there would be a delay in processing this. At the time of audit, the food control plan was still not available and although updated correspondence has since been provided, the registration documentation has not yet been provided.</p> <p>During inspection of the kitchen some temperature records and storage methods of dry goods were also found to be inconsistent with the requirements of the food plan.</p>	<p>An application for a food control plan has been lodged; however, this has not yet been actioned by the local district council. There are some practices not meeting the requirements of a food control plan.</p>	<p>The food control plan has been registered and approved by the relevant authority and the practices and reporting requirements of this are upheld.</p> <p>180 days</p>
<p>Criterion 3.5.7</p> <p>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.</p>	<p>PA Low</p>	<p>On a monthly basis, the infection control coordinator seeks out information on the number and type of infections from a variety of sources including from completed infection reporting criteria forms, the pharmacy used by the service provider and interviews with the team leaders in each hub. The total number of infections is recorded, and graphs are developed on the incidence of infections against benchmarking data, the number in each hub and the number on prophylactic antibiotics. It was reported that this is discussed at monthly health incorporated meetings. Quality meeting minutes included a report on the numerical data. There was no evidence of analysis, conclusions and specific recommendations made of this data to determine what strategies might be effective in preventing or controlling the spread of infections.</p>	<p>There is no current policy and procedure on the infection surveillance process and although the numerical data on the incidence of infections is being collected monthly, there is no evidence this is being analysed and evaluated to contribute to quality improvement processes for the prevention and control of infections.</p>	<p>A policy and procedure is developed to guide the processes to support conclusions and recommendations to be developed from infection surveillance data that will assist in achieving infection reduction and prevention outcomes.</p>

				180 days
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.