

Mercy Parklands Limited - Mercy Parklands

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
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric)
Dates of audit:	Start date: 22 September 2020 End date: 24 September 2020
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 Limited (Mercy Parklands) provides hospital level care for up to 97 residents. The service is operated by Mercy Healthcare Auckland, which is part of the Ngā Whaea Atawhai o Aotearoa Tiaki Manatu Sisters of Mercy Ministries. The facility is managed by a long serving chief executive officer (CEO) with clinical oversight provided by an operations manager and clinical services manager. Residents and families spoke positively about the care provided.

This certification audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, a family member, managers, staff, including allied health staff, and a general practitioner.

There were no areas requiring improvements as a result of this audit. There were four areas rated as 'continuous improvement' relating to the work in palliative care and the 'no-one dies alone' programme, the 'Silver Rainbow' programme, the volunteer 'Reading Buddy' programme and the development of an external walkway around the facility.

Consumer rights

<p>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.</p>		<p>All standards applicable to this service fully attained with some standards exceeded.</p>
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Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Services are provided that support personal privacy, dignity, independence and individuality. Staff interact with residents in a respectful manner.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent. Residents' choices are respected including via the development of end of life care plans and advance directives.

Residents who identify as Maori have their needs met in a manner that respects their cultural values and beliefs. There is no evidence of abuse, neglect or discrimination.

The service has linkages with a wide range of specialist health care providers to support best practice and meet residents' needs.

A complaints register is maintained with complaints resolved promptly and effectively.

Organisational management

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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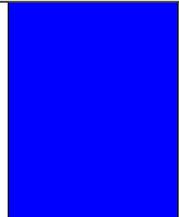
Business and quality and risk management plans included the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body was regular and effective. A suitably qualified person with extensive national connections within the sector manages the facility.

The well-established quality and risk management system includes collection and analysis of quality improvement data, benchmarking, identifies trends and leads to improvements. Staff are involved through a variety of portfolio roles and responsibilities 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 was based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and included regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

Residents' information was accurately recorded, securely stored and not accessible to unauthorised people.

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.		All standards applicable to this service fully attained with some standards exceeded.
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Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

The multidisciplinary team, including registered nurses, an occupational therapist, diversional therapist, physiotherapist, general practitioner, and chaplains, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and

needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other services as required.

The planned activity programme provides residents with a variety of individual and group activities.

Medicines are stored securely and administered by staff who are competent to do so. Processes are implemented to ensure residents self-administering medications are safe to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Mercy Parklands has a registered food safety plan and food services are provided in accordance with the plan. A 'dining with dignity and delight' programme has been implemented. Residents interviewed were satisfied with the food services.

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 meets the needs of residents and was clean and well maintained. There was a current building warrant of fitness. Electrical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provided shade and seating.

Waste and hazardous substances were well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment were safely stored. Most laundry was undertaken offsite, with a small laundry on site for some specific items. Laundry services are evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised. Residents reported a timely staff response to call bells. Security is maintained.

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. Eight residents had restraints in use at the time of audit. Approval and monitoring processes with regular reviews occur. Use of enablers is voluntary for the safety and independence of residents. Six residents had enablers in use at the time of this audit. Staff demonstrated 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.		Standards applicable to this service fully attained.
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The infection prevention and control programme is facilitated by the clinical support coordinator, and is focused on preventing and managing infections. The programme is reviewed annually. Additional infection prevention and control advice/support is obtained from an external contractor.

Staff demonstrated good principles and practice around infection control, which is guided by policies and supported with regular education and staff competency assessment processes. Appropriate personal protective equipment is available and observed in use, and visitor/staff risk screening is occurring due to Covid-19 level two restrictions.

The infection surveillance programme is relevant to the service setting and results are communicated appropriately.

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	3	47	0	0	0	0	0
Criteria	4	97	0	0	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>Mercy Parklands has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumer's Rights (the Code). Staff interviewed understood the requirements of the Code and were demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Residents and a family member interviewed confirmed this. Training on the Code is included as part of the comprehensive orientation process for all staff employed and in ongoing training, as was verified in training records. Health care assistants were observed calling residents by their preferred name.</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</p>	FA	<p>Nursing and care staff interviewed understood the principles and practices of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form including for photographs, invasive procedures and collection of health information.</p> <p>All new residents are admitted to hub one, and the initial nursing assessment and MDT reviews are completed. Following these, residents may be relocated to other room within Mercy Parklands once the resident's care needs have been fully assessed and documented. However, residents and family members are informed prior to admission that hub one may not be where the resident will remain, and this is included in the informed</p>

consent.		<p>consent processes/documentation on admission.</p> <p>Advance care planning, establishing, and documenting Enduring Power of Attorney (EPOA) requirements and processes for residents unable to consent is defined and documented, as relevant, in the resident's record.</p> <p>Verbal consent or refusal is obtained and documented from family members prior to initiating the 'no one dies alone' initiative for a resident (refer to 1.3.6.1). The feedback form subsequently given to applicable family members includes seeking feedback on the consent process.</p> <p>Staff were observed to gain consent for day to day cares and could articulate an escalation process to nursing staff if a resident repeatedly declines an aspect of care or declines food or fluid. A resident interviewed advised staff are respectful of the resident's wishes regarding hygiene cares and negotiate respectfully alternatives if the resident does not want a shower.</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>During the admission process, residents are given a copy of the Code, which also includes information on the advocacy services. Posters and brochures related to the advocacy services were also displayed and available in the facility. A family member and residents spoken with were aware of the advocacy services, how to access this and their right to have support persons. Staff were aware of how to access the National Advocacy Services.</p> <p>A family member of a resident is a 'resident advocate'. This is a formalised voluntary role to support residents with any needs/supports. The resident advocate attends the monthly community meetings (resident and family meetings) and is regularly on site.</p>
<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 are assisted to maximise their potential for self-help and maintains links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities and entertainments. The facility normally has unrestricted visiting hours and encouraged visits from residents' family and friends. However, during the audit, visitors' restrictions were appropriately in place as Auckland was at 'alert level two' of the national pandemic management plan. Residents stated that they were made aware of the reason for these restrictions. During Covid-19 visitor restrictions, staff work to assist residents with contacting family members via telephone and via electronic visual communication links. These endeavours were appreciated by residents interviewed.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer</p>	FA	<p>The complaints management policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so. The most common way to make a complaint was through an email.</p>

<p>to make a complaint is understood, respected, and upheld.</p>		<p>The complaints register reviewed showed that 18 complaints have been received over the past two quarters and that actions taken, through to an agreed resolution, are documented and completed within the timeframes. Complaints are a recent addition to the QPS benchmarking programme which the organisation is part of. This has resulted in an increase in complaints as the definition of a complaint has been broadened to include 'informal complaints'. Action plans showed any required follow up and improvements have been made where possible. The operations manager is responsible for the oversight of the complaint management process and follow up. Team leaders and staff within the hubs are involved, as appropriate. Staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p> <p>There have been two Health and Disability Commissioner (HDC) complaints received since the previous audit. One complaint received in May 2020 has been addressed and was closed, with a second complaint received in July 2019 still being worked through. All documentation requested from the HDC had been provided within timeframes required.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>Residents interviewed report being made aware of the Code and the National Health and Disability Advocacy Services (Advocacy services) through discussion with the staff and as part of the admission information provided. The service has a residents' advocate who attends the residents' meetings to ensure residents are kept informed. The Code is displayed on the notice boards at the entrance and communal areas together with information on advocacy services, how to make a complaint and feedback forms.</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>	<p>FA</p>	<p>Residents of Mercy Parklands and a resident's family member interviewed confirmed that they receive timely services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices. A chaplain and spiritual care coordinator are employed and provides support to residents of all faiths.</p> <p>Staff understood the need to maintain privacy and were observed doing so throughout the audit, when attending to personal cares, ensuring resident information is held securely and privately. All residents have a private room with an ensuite or shared toilet.</p> <p>Residents are encouraged to maintain their independence with choices of a variety of activities (refer to 1.3.7.1) including safe access to outdoor areas for activities (refer to 1.4.2.6), outings, and participation in clubs of their choice. Care plans included documentation related to the residents' disabilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff interviews demonstrated that staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Staff education on abuse and neglect was confirmed to occur during orientation</p>

		and annually.
<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>One resident reports their ethnicity as Maori, however, does not identify as Māori and has no specific cultural needs included in their care plan. Staff advise that any needs would be ascertained during the admission and ongoing assessment processes and incorporated into the resident's individual care plan.</p> <p>Policies detailing the principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau. Support and specific guidance on culturally appropriate care is available. A counsellor (Whaea) who has been a mission director in the past for the Sisters of Mercy has supported Mercy Parklands for over 20 years with the implementation of culturally appropriate care. This includes having input into the development of the Mercy Parklands business and strategic plan, providing advice and support as required/requested by staff/managers, supporting residents with any cultural needs and providing staff cultural and Tikanga training. All staff attended the six education sessions provided in the week prior to audit that was facilitated by Whaea on the 'Spirit of the Treaty of Waitangi' (TOW). Staff have previously been provided with other TOW training sessions. The 'Spirit of the Treaty' was recently chosen as this aligned well with the current focus - Mercy Parklands 'values in action'. Whaea was present on the first day of audit and assisted with the audit commencement and welcome.</p> <p>There are many staff cultures employed and Whaea advised providing support to any staff who requires this. Residents interviewed on this topic confirmed their cultural needs were met in a respectful and timely manner by staff. Family are encouraged to participate in their family member's care.</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 of Mercy Parklands and a family member verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident's personal preferences required interventions and special needs were included in care plans reviewed, for example, food likes and dislikes, communication needs, identification of dates/days that are culturally significant, and attention to preferences around activities of daily living. Residents cultural needs are also identified and documented as part of the end of life care planning processes in place (refer to 1.3.6.1).</p>
<p>Standard 1.1.7:</p>	CI	<p>Residents and a family member interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. A general practitioner (GP) also expressed satisfaction with the</p>

<p>Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>		<p>standard of services provided to residents. The work undertaken in relation to non-discrimination based on sexuality and gender identity is an area of continuous improvement.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>Mercy Parklands encourages and promotes good practice through evidence-based policies, inputs from external specialist services and allied health professionals. For example, the hospice team, clinical nurse specialist, dietitians and mental health services for older persons. The GP confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>There are a number of ongoing initiatives aimed at providing holistic care and improving quality of life of residents demonstrating a commitment to good practice and care delivered at Mercy Parklands. Staff also reported that they receive ongoing support for education.</p> <p>Quality improvement initiatives that have been undertaken including enhancing the external walkway and garden area (refer to 1.4.2.6) and the activities programme (refer to 1.3.7.1), and providing timely, respectful and well planned end of life care through the palliative pathway programme and no one dies alone (NODA) programme (refer to 1.3.6.1) and dining with dignity programme.</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. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. Following any incident, there is an area on the paper incident form to indicate who has been informed, when and by whom. This was completed in the forms reviewed.</p> <p>Staff know how to access interpreter services, although reported this was rarely required due to most residents able to speak English, the support of family members and the many multi-lingual/cultural staff available to assist.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures</p>	<p>FA</p>	<p>The Integrated Business and Quality Plan, which is reviewed annually, outlines the purpose, values, scope, direction and goals of the organisation. The documents described annual and longer-term objectives and the associated operational plans and measures. The plan included human resources, information technology, health and safety, capital expenditure (Capex) and training requirements, for example. The organisation is</p>

<p>services are planned, coordinated, and appropriate to the needs of consumers.</p>		<p>working through an inclusive process to review the values. The Australian based 'Spark of Life' programme previously implemented across the organisation has been superseded by the organisation's own Mercy Model of Care to better reflect the Mercy values and mission. This person-centred model is part of the induction process for all staff with regular ongoing education of staff and residents.</p> <p>A sample of bi-monthly reports to the board of directors and interview with the chair of the board and CEO of Mercy Healthcare showed adequate information to monitor performance is reported including financial performance, emerging risks and issues.</p> <p>Mercy Parklands is managed by a CEO who has been in the role for many years and is a director on the New Zealand Aged Care Association (NZACA), a member of the Ministry Palliative Care Advisory Panel and the Health Quality & Safety Commission advance care planning group. Responsibilities and accountabilities are defined in a job description and individual employment agreement.</p> <p>The service holds Aged Related Care (ARC) contracts with the Auckland DHB (ADHB) for hospital level care, interim care, long term care (LTC) and respite care and with Mercy Hospice and the ADHB for palliative care. At the time of audit, there were two residents under a young person with a disability (YPD) contract. Eight-five (85) residents were receiving services under the ARC contract for hospital level care. There were three residents receiving care under the interim care contract, one resident receiving respite care and one resident who is part funded through ACC and part funded through the DHB. There were no residents under the palliative contract.</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>When the CEO is absent, the operations manager carries out all the required duties under delegated authority. During absences of key clinical staff, the clinical management is overseen by either the operations manager, the clinical service manager (CSM) or clinical support coordinator. All are able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p>	<p>FA</p>	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This included management of incidents and complaints, an extensive audit programme, regular satisfaction surveys and focus groups covering activities, the food service, the interim care contract, family specific surveys, pastoral care, staff and GP satisfaction surveys. Monitoring of outcomes occurs through New</p>

<p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>Zealand and Australasian benchmarking programmes and trending of clinical incidents including infections and complaints.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the wide range of staff and management team meetings including the HR Insight meetings, RN meetings, Health Incorporated (health, safety & wellbeing), the quality and risk meetings and the community meeting (resident and family meeting). Staff reported their involvement in quality and risk management activities through a range of portfolio responsibilities including for falls management, restraint minimisation, infection prevention and control, preceptorship and complementary therapies and a wide range of audit activity. There are a large number of quality improvement projects either in progress or completed since the previous audit. These involve staff, residents and family members and include the palliative care pathway, the 'Dining with dignity and delight' project, the 'Dance for Life' programme for residents living with dementia, the 'Reading Buddies' programme, and the diversity 'Silver Seal' programme. Relevant corrective actions are developed and implemented to address any shortfalls identified through the complaints, feedback, incident and audit processes. Several of the most recent surveys showed a high level of satisfaction specific to the survey with opportunities for improvements identified and a planned approach to make improvements. These are discussed at quality and staff meetings.</p> <p>Policies reviewed covered 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, reference accordingly and were current. The document control system ensures a systematic and regular review process, approval, distribution and removal of obsolete documents.</p> <p>The CEO and operations manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The operations manager oversees the health, safety and wellness programme and was familiar with the Health and Safety at Work Act (2015) and has implemented requirements.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice</p>	<p>FA</p>	<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 a range of meetings, including staff, the leadership team and the quality forum. A wide range of indicators are benchmarked through the 'QPS' benchmarking programme and a New Zealand aged care safety indicator programme. Data is graphed trended and discussed using a risk trend matrix.</p> <p>The CEO and operations manager described essential notification reporting requirements, including for pressure injuries. There have been several notification made to the Ministry of Health in relation to facility and non-facility acquired pressure injuries, one notification in relation to a new appointee in the clinical service manager role, and one notification, made during the audit, in relation to a previous change of</p>

in an open manner.		governance/director membership.
<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. There are volunteers used on a regular basis (prior to Covid-19 restrictions) to support a range of programmes including activities, staff support, companionship and the volunteers who support the 'no one dies alone' initiative. There is a selection process, orientation and ongoing training and support provided. A sample of 10 volunteer files were reviewed and showed appropriate recruitment information. A volunteer coordinator oversees the programme.</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. Fourteen staff records reviewed showed documentation of completed 'on-boarding', with a few exceptions where this was not yet due for completion or had not yet been filed, and a performance review after a three-month period (where applicable).</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority (NZQA) education programme to meet the requirements of the provider's agreement with the DHB. The rostering data and information used to review staffing requirements notes the level of qualification of health care assistants (HCAs) along with other competencies (e.g., medication competency). This showed a high number of HCAs practising at level 4 on the career progression scale. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.</p> <p>Due to several recent RN resignations and recent appointments there was a reduced number of staff to complete interRAI assessments. At the time of audit, there were 10 staff interRAI competent with one RN booked to attend in October and plans for further RNs to attend over the next few months. At the time of audit, the CSM reported that all assessments were up to date; however, there are several due in the near future due to new admissions and several reassessments needed. There is a plan in place to manage this. Mercy Parklands is now part of the ADHB Professional Development and Recognition Programme (PDRP) with registered nurses (RNs) working towards completion of the required competency portfolios. There is also a Nursing Entry to Practice (NETP) programme with two new graduate RNs on this programme at the time of audit.</p>
Standard 1.2.8: Service Provider Availability	FA	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 facility adjusts staffing levels to meet the changing needs of residents. Each clinical area hub (five) has their own roster and the staffing allocation

<p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>process aims to provide continuity of care within the hubs, with some flexibility as needed. A regular weekly meeting is held with the management team supported by extensive HR data for each hub (hub bio). This forum reviews current staffing (HCA, RN and team leader (TL)) requirements and any variance between required FTE and actual FTE. Allied health, activities staff, catering, housekeeping, support and management staff are also defined and reviewed as needed. Mercy Parklands employs one full time occupational therapist and a physiotherapist (physio) visits on Monday, Tuesday and Wednesday (16-18 hours/week). There is a safe handling coordinator (trained by the physio) and two therapy assistants who implement physio plans for individual residents and run the 'balance & exercise classes' designed by the physio.</p> <p>An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. HCAs reported there were adequate staff available to complete the work allocated to them. Residents (with a couple of exceptions in one of the hubs) and family interviewed supported this. Observations and review of a recent roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. Mercy Parklands have their own small casual pool and part time staff are able to increase hours to fill in unplanned vacancies, as needed. There is a quarterly audit completed of staffing requirements and staffing is also benchmarked. The most recent audit resulted in some changes to increase the number of TL days for administration and several other actions in progress to make improvements. At least one staff member on duty has a current first aid certificate and there is always two RNs on duty during the night, five RNs on each morning and four each afternoon shift. Each shift has a designated duty leader.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. Records were legible with the name and designation of the person making the entry identifiable. This includes interRAI assessment information entered into the Momentum electronic database.</p> <p>The residents' name, date of birth and National Health Index (NHI) number are used on labels as the unique identifier on all residents' information sighted. Medicine records are maintained electronically.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system.</p> <p>Residents' files are held for the required period before destroyed. No personal and private resident information was on public display during the audit.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a</p>	<p>FA</p>	<p>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service or gerontology service as requiring aged-related hospital level of care. The service also provides hospital level care to residents under an 'interim care contract' with Auckland District Health Board (ADHB), provides respite care at hospital level, and palliative care.</p>

<p>competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>		<p>Prospective residents and/or their families are encouraged to visit the facility prior to admission (depending on any Covid-19 restrictions in place) and are provided with written and verbal information about the service and the admission process. Where necessary staff provide a virtual tour via phone. Mercy Parklands seeks current information from the applicable clinical teams and NASC to ensure the prospective residents' needs can be safely met. The operations manager (OM) is responsible for managing residents' enquiries, with input from the clinical service manager (CSM) or the clinical support coordinator (CSC).</p> <p>Residents interviewed on this topic stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic details, assessments and signed New Zealand Aged Care Association admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements.</p> <p>Information on the services at Mercy Parklands are communicated via the NASC service, faith-based community links, the Eldernet website, and word of mouth. A waiting list is kept of residents when there are no beds available, or the enquiry relates to a future admission date.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>Exit, discharge or transfer is managed in a planned and coordinated manner, with an escort as appropriate. The service uses the DHB's yellow envelope system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family/whanau. At the time of transition between services, appropriate information, including medication records and the care plan is provided for the ongoing management of the resident. All referrals are documented in the progress notes. No resident has required transfer to a secure dementia unit since hub two was established for the care of residents with cognitive/memory difficulties in 2012. Residents confirmed communication with staff was timely and clear about all aspects of care.</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>	<p>FA</p>	<p>The medication management policy was current and included required components to meet these standards. Standing orders are not used.</p> <p>A safe system for medicine management was observed on the days of audit. The RN observed demonstrated good knowledge and had a clear understanding of their role and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage. Completed competencies were sighted and included, where applicable, 'Niki-T' syringe driver, intravenous therapy competencies, controlled drugs and medicine competency. The electronic medicine records for 20 residents were reviewed. These were legible and each entry has been signed by the GP. The date medicines commenced was noted. Discontinued medicines have been dated and signed or were noted to have a stop day when prescribed. Indications are noted for pro re nata (PRN) medicines. Assessments for medication sensitivities and allergies is noted. Medicine reconciliation is occurring. There is a photograph of the resident on</p>

		<p>each medicine chart. These photos are updated regularly.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. All medicines are checked against the medicine record on delivery. An RN checks the contents of the medicine supplied against each resident's individual medicine record before putting the medicines into use. The RN was observed to check this information again at the time of administration. All medications sighted were within current use by dates.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly stock checks and accurate entries.</p> <p>Mercy Parklands is 'cold chain accredited' with a certificate issued on 12 March 2020. There were no vaccinations currently on site, however, cold chain accreditation processes are used when the staff and resident vaccination programmes are being undertaken. Prior consent is obtained for the administration of any vaccine. The medications that require refrigeration are stored appropriately. The temperature of the refrigerator is monitored daily and is within the required temperature range. The ambient temperature of the room where medicines are stored is also being monitored and is within the required range and records were being retained.</p> <p>One resident was self-administering medications. Processes were in place to ensure the resident was safe to do so.</p> <p>There is an implemented process for the reporting, management of, and analysis of medication errors. Aspects of medicine management are reviewed via the Mercy Parklands internal audit programme.</p> <p>Residents interviewed on this topic verified they are informed of medicines at the time of administration and any changes in medications that have been prescribed.</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>The food services are provided on site by employed staff. There are two cooks working each day along with other staff. The main meal is served in the evening.</p> <p>Applicable staff have completed food safety training. The menu is a five-week seasonal rotating menu. The current menu has been reviewed by a qualified dietitian and approved as being appropriate for the residents. The service has an approved food safety plan. Implementation of the food service plan has been subsequently verified with 100% pass in the most recent audit. The 'A' grade food rating is displayed at Mercy Parklands. All aspects of production, preparation, storage and disposal comply with current legislation and guidelines.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility by nursing staff and a dietary profile is developed. The personal food preferences, any special diets, cultural needs, and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment to meet resident's nutritional needs, is available. Nutritional supplements are also available and</p>

		<p>used where clinically indicated / prescribed.</p> <p>Residents' satisfaction with meals was verified by resident and family interviews.</p> <p>There is adequate food supplies and special diets and/or supplementary foods are catered for appropriately. This includes food and water supplies for use in a civil defence emergency.</p> <p>Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided in a respectful manner. Where preferred, residents can eat their meals in their room and staff assistance is also provided as required. A 'dining with dignity programme' has been undertaken as a quality improvement programme. This is designed to ensure mealtimes, socialisation opportunities with each other, staff support, and dining ambience are optimised to enhance the resident dining experience. In addition, work and staff training has been undertaken in relation to texture modified meals. An internal audit programme has been implemented to ensure modified texture meals are provided in accordance with requirements.</p>
<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>If a referral is received but the prospective resident does not meet the entry criteria or there is no vacancy, the local NASC is advised along with the prospective resident and family, in order to support them to find an appropriate care alternative. Alternatively, the prospective resident is placed on a wait list if urgent admission is not required.</p> <p>If the needs of a resident changes and they are no longer suitable for the current services provided, the clinical manager advised a referral for reassessment to the NASC would be made. Since 2012, when Mercy Parklands developed hub two with a focus for caring for residents with cognitive and memory difficulties, no resident has required transfer from Mercy Parklands to a secure dementia facility.</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>Information is documented using validated nursing assessment tools, such as interRAI, skin integrity, falls, continence assessment, pain assessment, quality of life index, as a means to identify any deficits and to inform care planning. The occupational therapist and physiotherapist also complete an assessment within 21 days of admission. A multidisciplinary review is undertaken with resident and/or family input on at least a six-monthly basis, or sooner where required. A GP was observed discussing with a family member the results of assessments undertaken including laboratory investigation results for their family member that has new and significantly changing needs.</p> <p>The sample of care plans reviewed had an integrated range of resident related information. All residents have current interRAI assessments completed by one of ten interRAI competent assessors onsite. Residents and</p>

		<p>families confirmed their involvement in the assessment process. Based on their assessment, an ongoing plan is put in place and are implemented by the therapy assistants.</p> <p>There is a resident social / life history assessment completed which is used to inform the resident's activities plan.</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>Residents' files reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the assessments were reflected in care plans reviewed. This includes supporting residents with cognitive, communication, cultural, behavioural, and day to day care needs.</p> <p>Care plans evidenced service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plan. Short term care plans are in place to manage the acute health issues. Health care assistants interviewed confirmed they are advised of changes in residents' care plans in a timely manner.</p> <p>A folder is maintained in each hub for quick reference of residents with a short-term care plan in place, and for recording any resident falls, infections and wounds as they are identified during the month.</p> <p>A monthly wall chart in each hub also identifies the date and room number of any resident that has fallen or who has a skin tear for quick reference.</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>	CI	<p>Documentation, observations and interviews verified the care provided to residents was consistent with their needs, goals and the plan of care. Residents and a family member interviewed were very satisfied with the quality of care and services provided at Mercy Parklands. Mercy Parklands continues to review the care processes related to residents receiving palliative care or who are actively dying and have implemented a 'no one does alone' (NODA) programme. This is an area of continuous improvement.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity</p>	CI	<p>The activities programme currently covers group and individual activities to meet the needs of hospital level residents, including residents with altered function and cognition/memory. The activities programme is facilitated Monday to Saturday. A team member also attends for two hours on Sunday to help with residents accessing chapel services or to support residents with faith-based activities in their room. The 'spark of life' philosophy was previously used as guidance for the activities programme and more recently the new Mercy Parklands</p>

<p>requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>Model of Care – Mercy in your heart, Mercy in your head and Mercy in your hands.</p> <p>Mercy Parklands has developed a ‘reading buddy programme’ and has other volunteers supporting residents with activities (Covid-19 level precautions permitting). These initiatives have been given national awards by the Minister of Health in 2019. The Minister of Health volunteer award (winner), outstanding achievement for the ‘reading buddies programme’, and the runner up award for the ‘volunteer programme’ was awarded to Mercy Parklands. The activities programme is an area of continuous improvement.</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 on each shift and reported in the progress notes. If any change is noted, it is reported to the RN by health care assistants verbally and using the ‘stop and watch tool’.</p> <p>A comprehensive multidisciplinary review, which includes resident, family member, GP and other allied health members, is conducted at least three monthly to evaluate the care of residents, and in conjunction with the six monthly interRAI reassessment. Paper based assessments and the care plans are updated three monthly or as needed and where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short-term care plans being consistently reviewed, and progress evaluated as clinically indicated were noted and included in response to falls, wounds or infections. As a recent initiative, the registered nurses are required to review the resident as specific follow up each shift over 24 hours following any reported incident/adverse event. These reviews are ‘stamped’ in the resident’s records, so they stand out. The clinical manager monitors that this is occurring. When necessary, and for unresolved problems, long term care plans are added to and updated. Residents and the family member interviewed confirmed their involvement in evaluation of progress and any resulting changes.</p> <p>At least monthly weight and vital signs were recorded for each resident, or sooner where requested / indicated. The results of laboratory investigations and analysis were present in residents’ files sampled</p>
<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</p>	<p>FA</p>	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a contracted GP service, residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist inputs. Copies of referrals to MHSOP, and dietitian were sighted in residents’ files. The residents and the family/whanau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending to accident and emergency in an ambulance if the circumstance dictate. The clinical services manager advised reviews are undertaken of transfers out to the DHB hospital to ensure these occur appropriately.</p>

consumer choice/needs.		
<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>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. The maintenance manager is the appointed waste manager officer. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored, and staff interviewed knew what to do should any chemical spill/event occur. There are chemical and cytotoxic spill kits available (sighted). LPG cylinders were stored safely, as were oxygen cylinders, which are checked daily. There is a hazardous substances register. An audit in May 2020 of waste management showed 100 percent compliance.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this. There was a large store of protective equipment from the DHB specific to the needs of managing the Covid-19 pandemic.</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>A current building warrant of fitness (expiry date 14 October 2020) was publicly displayed. Checks for renewal were well underway.</p> <p>Appropriate systems were in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The maintenance manager described the planned and unplanned maintenance programme. Staff enter any maintenance requests into a maintenance book within each hub. This is checked daily. The testing and tagging of electrical equipment and calibration of bio medical was current. The environment was hazard free, residents were safe, and independence is promoted. There has been a long-standing issue with one lift which has resulted in a new lift being installed. This was about to be fully operational with the final 'sign off'. The area was safely secured in the interim.</p> <p>External areas are safely maintained and were appropriate to the resident groups and setting. A CI rating is made in relation to a project completed in February 2019 to provide a walkway and wheelchair way around the grounds to improve fitness, balance and mental and social wellbeing of residents. Additional 'speed bumps' have been installed to reduce the speed of cars around the facility. There is a designated walking strip to promote safety within the car park area. Signage alerts people to any hazards. A new external walkway for residents to use and enjoy around the grounds has been a successful project providing increased opportunities for exercise within a safe setting. Residents in hub 2 who have specific needs related to living with dementia, have a safe and purpose-built courtyard area to support their needs.</p> <p>Staff confirmed they know the processes to follow if any repairs or maintenance are required and that any requests are appropriately actioned. Residents were happy with the environment.</p>

<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. Five rooms have full ensuites, twenty-five rooms have their own toilet and 66 standard rooms share a toilet. All rooms have a hand basin. In addition, all wings have larger shower areas to enable assistance and extra equipment. There is also a spa bathroom set up to facilitate relaxation and 'pampering'. Appropriately secured and approved handrails were provided in the toilet/shower areas, and other equipment/accessories were available to promote residents' independence.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation, with several 'double' rooms available to accommodate couples, if needed. There were no couples sharing rooms at the time of audit. There are 96 rooms available, but the facility is licensed to accommodate 97 residents. Rooms were personalised with furnishings, photos and other personal items displayed.</p> <p>There was room to store mobility aids, wheelchairs and mobility scooters. Staff and residents reported the adequacy of bedrooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>Six separate communal areas are available for residents to engage in activities. These dining and lounge areas are spacious and enable easy access for residents and staff. Residents can access areas for privacy, as required. Furniture is appropriate to the setting and residents' needs. Furniture has been arranged to support social distancing during the Covid-19 pandemic. Visitors are required to be in residents' rooms during the level 2 requirements, in place during the audit.</p>
<p>Standard 1.4.6: Cleaning</p>	<p>FA</p>	<p>Most laundry is undertaken off site by a contracted service. There has been a recent change of service provider. There is also a small onsite laundry for a range of specific items. Dedicated laundry staff are trained in</p>

<p>And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>		<p>how to use the two washing machines in the area and laundry processes. The housekeeping team leader and a person recently employed on a specific project contract basis were interviewed. There has been a review and improvements made to both laundry and cleaning services over the past few months due to resident and staff feedback and audits showing less than optimal performance. There have been some minor difficulties with the new laundry provider who use an 'ozone' laundering system. These are being worked through with the provider. Recent audits showed improvements in laundry services.</p> <p>There is a small, designated cleaning team who have received appropriate training. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers.</p> <p>Cleaning and laundry processes are monitored through the benchmarking and internal audit programme and through satisfaction surveys. The environment was clean and tidy during the audit. Recent audits showed improvements in cleaning.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Policies and guidelines for emergency planning, preparation and response were displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and described the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service on the 27 June 2018. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service. This was delayed due to the Covid-19 lock down requirements. However, an evacuation was undertaken two weeks prior to this audit. The documentation sent to the fire service showed an effective evacuation with some areas highlighted for improvements implemented. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures. Records reviewed demonstrated that emergency coordinator training occurred in 2020 with ongoing 'toolbox' training for staff covering a range of areas. Staff competency related to fire and emergency skills is also monitored through the external benchmarking programme, which showed a high level of compliance.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ's were sighted and meet the requirements for the 97 of residents. Water storage tanks are on the complex, and there is a newly installed generator on site. Emergency lighting is regularly tested. Monthly audits of emergency equipment occur and showed good compliance.</p> <p>Call bells alert staff to residents requiring assistance. Call system audits are completed regularly, and residents and families reported staff responded promptly to call bells.</p> <p>Appropriate security arrangements were in place. Doors and windows are locked at a predetermined time and a security company checks the premises at night. Exit doors are electronically monitored between dusk and dawn.</p>

<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Each room has their own heater and there are heaters in the communal areas. Rooms have natural light, opening external windows and there are several easy access doors to the internal courtyard areas. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.</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>The service provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a current infection control policies and procedures. The infection control programme is reviewed annually (January 2020). Mercy Parklands is implementing a range of precautions for staff, residents, family members and visitors as the result of the Covid-19 pandemic, and these precautions have changed over time based on the national alert level in place at the time, and information provided by the Ministry of Health, Public Health service, the Residential Aged Care Association and ADHB. Mercy Parklands is about to undertake a third round of Covid testing for staff. This is voluntary. In addition, Covid testing is undertaken as and when clinically appropriate for individual staff and residents. There have not been any Covid-19 positive results to date.</p> <p>Mercy Parklands has also undertaken a review in 2019 of staff's immunity to measles. Staff were offered free serology testing if they were unsure of their status. New staff are now required to provide evidence of immunity prior to employment and encouraged to see their GP for measles vaccination where indicated.</p> <p>The clinical support co-ordinator is responsible for coordinating the infection prevention and control programme with the support of the wider RN and management team, having been appointed to this role in April 2020. The role and responsibilities of the infection prevention and control nurse is documented. There are preceptors (volunteer infection prevention and control representatives) working in each hub/area. The preceptors meet monthly.</p> <p>Infection control matters, including surveillance results, are discussed monthly in various staff meetings including the infection prevention and control preceptor meetings, the quality committee meeting, the three-monthly GP meetings and general staff meetings.</p> <p>Staff and residents are offered an annual influenza vaccination. All staff accepted the annual influenza vaccination in 2020, along with consenting residents.</p>

		<p>Staff interviewed understood their responsibilities to prevent the spread of infection. Appropriate personal protective equipment (PPE) is available and was observed to be in use.</p> <p>Compliance with key aspects of policy is monitored via the internal audit programme</p>
<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 clinical support coordinator (CSC) is a registered nurse and is responsible for co-ordinating the infection prevention and control (IP&C) programme for Mercy Parklands. As the CSC is new in this role, there are formal supports in place from an external infection prevention and control nurse who is familiar with Mercy Parklands facility and systems. Infection prevention control advice and support is available for the CSC at any time via phone, email or in person meetings. The IP&C training the CSC had planned to attend since starting in the role has been deferred due to Covid 19 restrictions.</p> <p>If required expert advice can also be sought from the community laboratory and/or the general practitioner, and the other health agencies. Regular updates and communications have been received in relation to Covid 19. The operations manager maintains a folder of these communications.</p> <p>The CSC/IP&C coordinator has access to residents` records and diagnostic results to ensure timely treatment and resolution of any infections and confirmed the availability of resources to support the management of any outbreak of an infection should this be required.</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</p>	FA	<p>The infection prevention and control policies reflected the requirements of the infection prevention and control standard and current accepted good practice. Policies were current. A paper-based copy of all the policies are available for staff to access in each hub. The external infection control consultant is assisting with applicable policy and procedure review.</p> <p>Care delivery, cleaning, and kitchen staff were observed following organisational policies, such as appropriate use of hand sanitisers, good handwashing techniques and use of disposable gloves, as appropriate. Hand washing and sanitiser dispensers were available in designated areas around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>

provided.		
<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 previous IP&C coordinator was supported to attend the national infection prevention and control conference. The CSC/IP&CC has access to appropriate supports for advice, guidance and support in provision of staff education where required. Education is also provided by wound care specialist nurses and palliative care services where applicable.</p> <p>The staff education plan includes infection prevention and control. This commences during orientation and has been continued in the ongoing education programme. Records are maintained of all infection control education provided. Ninety eight percent of staff have completed a hand hygiene competency in 2020. This is a resource provided by an external infection prevention and control advisory service. In addition, there is an annual infection prevention and control competency that assesses staff knowledge on a variety of other related topics. Ninety-six staff completed this training in 2019 with the previous IP&CC, with one other staff member completing the requirements in July 2020. The annual IC competency is scheduled to re-occur in the last quarter of 2020.</p> <p>Education with residents is generally on a one-to-one basis and included aspects of personal hygiene, the benefits of the influenza vaccination, and the prevention of urinary tract infections or the treatment plan for new infections. These communications are documented in short term care plans or the narrative of progress notes.</p> <p>A video has been used to help inform residents about Covid-19.</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>	FA	<p>Surveillance is appropriate to that recommended for a long-term care facility. This includes urinary tract infections, wound infections, eye, mouth and ear infections, chest infections, multi drug resistant organisms, skin and soft tissue infections, scabies and head lice and other infections. When an infection is identified a record of this is documented on a designated register by the RN who is responsible for the resident's care at the time of diagnosis, and also detailed in the applicable resident's file. The infection prevention and control coordinator reviews all reported infections and maintain a summary of information including the name of the resident, the type of infection, the results of laboratory investigations (if applicable), the treatment including antibiotics used and the outcome. The residents' infections as detailed in the sampled residents' files have been included in the infection surveillance data in the month the infection was diagnosed.</p> <p>In addition, the laboratory sends through a fortnightly report of all positive microbial cultures.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff. New resident infections are communicated to staff via the shift handover and discussed at the weekday 8.30 am 'stand-up meeting' attended by the management team and representatives from each hub. There are documented definitions of infection for consistency. Urinary tract infections (UTI) and respiratory tract infections are benchmarked</p>

		<p>externally with some other facilities.</p> <p>There have been three episodes or clusters of infection investigated since the last audit. In April and May 2019 six residents across two hubs and two staff were diagnosed with probable scabies, and appropriate treatment was implemented. In July 2019, a resident in one hub was suspected of having scabies. All staff and residents in this hub were treated. A cluster of four residents with diarrhoea was investigated in August 2019. The symptoms were subsequently contributed to non-infectious causes.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<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 clinical manager is the restraint coordinator and provides support and oversight for enabler and restraint management in the facility. The clinical manager demonstrated a good understanding of the organisation's policies, procedures and practice and their role and responsibilities.</p> <p>There were eight residents using restraints and six residents using enablers on the days of audit. Restraint and enabler registers are maintained. Restraint is only used as a last resort when all alternatives have been explored. This was evident on review of the restraint/falls group meeting minutes, resident files reviewed, and from interviews with staff. Staff are provided with training on the use of restraints and enablers as a component of the staff orientation and education programme. The records of three residents using restraints and two residents using enablers were reviewed. Family members of residents with restraint in use were not able to be interviewed.</p> <p>Enablers are voluntary and used to help promote the resident's independence as confirmed during interview with a resident using an enabler.</p>
<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</p>	FA	<p>The clinical services manager is the restraint co-ordinator. The role/responsibilities of the restraint coordinator are documented. The clinical services manager/restraint coordinator and the five team leaders were interviewed. Prior to any restraint being implemented, the clinical services manager/restraint coordinator or the duty leader (designated team leader/RN each shift) must be consulted. The need is also discussed with the resident or family member/enduring power of attorney. The general practitioner and allied health team are consulted on their next working day.</p> <p>The clinical services manager reviews restraint minimisation and safe practice for each individual resident.</p> <p>It was evident from review of the falls/restraint group meeting minutes, review of residents' records and interview with the clinical services manager and team leaders that there are clear lines of accountability that all restraints have been approved, and the overall use of restraint is monitored and analysed.</p>

<p>process is made known to service providers and others.</p>		<p>Evidence of family involvement in the decision making as required by the organisation's policies and procedures was on record in each case and the use of restraint is included in the care planning process and documented in the plan of care.</p>
<p>Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>Prior to restraint being used an assessment is undertaken that includes the components required to meet this standard, and the outcomes documented in the residents record as sighted in applicable resident files during audit. The five team leaders interviewed confirmed appropriate assessments are required to be completed, and family, consulted before any restraint is considered.</p>
<p>Standard 2.2.3: Safe Restraint Use Services use restraint safely</p>	<p>FA</p>	<p>The use of restraints is actively minimised, and the clinical manager and five team leaders described how alternatives to restraints are considered and discussed with staff and family members. Time is spent explaining how the resident can be safely supported and suitable alternatives, such as trying to engage the resident in meaningful activities, are explored before use of a restraint is implemented. When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. Records reviewed contain the necessary details, access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected. This is included in the resident's care plan and monitoring forms reviewed recorded that this had occurred as required.</p> <p>A restraint register is maintained and reviewed at each falls/restraint group meeting. The register was reviewed and contained all residents currently using a restraint and sufficient information to provide an auditable record.</p> <p>Staff have received training in the organisation's policy and procedures and in related topics, such as positively supporting people with challenging behaviours. Health care assistants and the activities staff spoken to understood that the use of restraints is to be minimised and how to maintain safe use was confirmed. There is an annual staff competency on the use of restraint and enablers.</p>
<p>Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>Review of residents' records evidenced the use of restraints is reviewed and evaluated during the care plan and interRAI reviews, three monthly care plan evaluations and at the restraint group meetings. In addition, restraint use is discussed at the six-monthly MDT meetings.</p> <p>The restraint/falls group meets every three months and membership includes the restraint coordinator, the team leaders of each hub (five), the allied health coordinator, the occupational therapist, the physiotherapist and the safe handling coordinator. This group reviews the restraint and enabler register and discusses each resident</p>

		with restraints in use to ensure the use of restraint is still appropriate, and to discuss any alternatives that should be considered. Any amendments required to policy or staff education are also discussed.
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>The restraint/falls group undertakes a review of restraint use and includes the components required to meet this standard. Mercy Parklands benchmarks the use of restraint externally. The restraint use at Mercy Parklands is currently higher than some of the comparative benchmarked facilities. The clinical manager/restraint coordinator advised being fully aware of this and that all restraints in use are regularly reviewed and are clinically appropriate. This is verified in the restraint/falls group meeting minutes and applicable resident records sighted.</p> <p>Any adverse events associated with the use of restraint are reported via the incident reporting system and investigate and actioned.</p> <p>In addition, there is an annual report on the use of restraint at Mercy Parklands. The report for the period ending December 2019 was sighted. And includes evaluation of the number of residents with restraints in use, reasons, trends, staff education and future goals. The use or restraint per hub each month is reported/graphed.</p>

Specific results for criterion where corrective actions are required

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

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

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

No data to display

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 1.1.7.3</p> <p>Service providers maintain professional boundaries and refrain from acts or behaviours which could benefit the provider at the expense or well-being of the consumer.</p>	CI	<p>The induction process for staff includes education related to professional boundaries, expected behaviours, the Human Rights Act and the Code of Conduct. All Registered Nurses (RN) have records of completion of the required training of professional boundaries.</p> <p>Staff are guided by policies and procedures and demonstrated a clear understanding of the process they should follow and should they suspect any form of exploitation, discrimination or abuse. Mercy Parklands demonstrates continuous improvement for the ongoing work related to ensuring a safe place for staff and residents related to gender and sexuality identity.</p>	<p>In February 2016 a working group was developed with an aim for Mercy Parklands to work towards gaining the ‘Silver Seal’, a logo indicating that Mercy Parklands is a safe place for those with diverse sexualities and gender identities. A vision statement was developed ‘building confidence through education and support to make Mercy Parklands a welcoming place for people with diverse sexualities’. Staff volunteer to be part of the silver seal team. There are currently five members in this team which is facilitated by the chaplain and spiritual care coordinator. A silver rainbow toolbox has been developed with the support of Te Hopai Trust Group. Staff were provided with training by external education with 40% of staff completing the initial training (2016) and 67% of staff completing the training in 2019, and this is included in the staff ‘onboarding’ programme. The Silver Seal was awarded to Mercy Parklands in September 2017 and reaffirmed in 2019. A staff questionnaire assessed staff feedback on the training received. The respondents all identified they now felt more confident to care for residents who express differing sexual and gender identities and now feel comfortable communicating with those with differing sexual and gender identities. Staff interviewed identified the</p>

			<p>Silver Seal training helped them understand better their own values and beliefs and how these may impact in the care of others, and in demonstrating the Mercy Parklands values in day to day care of all residents.</p> <p>All Mercy Parkland residents and staff templates and clinical forms have been reviewed to ensure gender neutral/non-discriminatory language is used. A review of all Mercy Parklands policies and procedures has included ensuring gender neutral and non-discriminatory language and focus for staff and resident care.</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>CI</p>	<p>The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is delivered according to instructions.</p> <p>Records are made of the residents that need to be seen by the GP each visit. This includes routine reviews or if there are any issues requiring follow-up or new concerns. Copies of laboratory results are reviewed and signed by the GP.</p> <p>Care staff confirmed that care was provided as outlined in the documentation. A range of equipment including air mattress, pressure relieving cushions and other resources were available, suited to the levels of care provided and in accordance with the residents' needs.</p> <p>The care planning processes, and interventions related to residents receiving palliative care or who are actively dying, and the 'no one does alone' (NODA) programme demonstrated continuous</p>	<p>In addition to other care planning processes, the palliative pathway activation (PPA) as part of the palliative outcome initiative (POI) is used to facilitate individualised palliative care planning for residents where it is anticipated they may have a life expectancy of under six months. These pathways are developed with the resident and or family and submitted electronically to Mercy Hospice for review and feedback as part of advanced planning to ensure end of life care is provided with dignity and comfort. Mercy Parklands has submitted 104 of the PPA's since the commencement of POI (2017) out of the 426 reported to have been received to date by Mercy Hospice. In addition, the last days of life care plan is implemented when the nursing assessment indicates the resident is actively dying.</p> <p>In addition to these initiatives, the Mercy Parklands 'No One Dies Alone' journey began in May 2017. This was initiated in order to provide a compassionate and caring presence/support with consent to residents who may otherwise die without a companion present. Volunteers are provided with training on the role. There are currently 40 volunteers trained. There are processes in place to ensure volunteers are appropriately selected, orientated and trained. The care processes supporting the NODA initiative are documented in 'a compassionate companion manual' which includes the compassionate companion volunteer guide. Over the last three years the NODA volunteer orientation programme has been reviewed and refined. The latest orientation programme run in March 2020 included six women and two men, who learned many aspects of the person's final days/hours. The NODA orientation programme is formally evaluated by attendees and feedback</p>

		improvement.	<p>used to inform future training. Volunteers are not included in the ongoing NODA programme if there are any concerns about their suitability for this role.</p> <p>Between August 2019 and August 2020 Mercy Parkland has had 40 resident deaths. Within 72 hours of expected death the family are offered the choice of NODA, and consent is obtained or declined. Most programme recipients are elderly people without loved ones nearby, or NODA allows the family some respite time when they are at the bedside. The NODA programme was particularly important during the Covid-19 visiting restrictions with staff rotating to stay with dying residents when family and friends were unable to do so. One dying resident received 40 hours of companionship care by staff. Mercy Parklands monitors each month the number of residents that have died, the number with PPA, whether the family/resident consented to have NODA support and whether the last days of life care plan was activated for the resident (staff are identifying when residents are actively dying). A satisfaction survey is offered to family members to assess their level of satisfaction with the NODA programme, staff communication and whether they were asked to provide consent for NODA programme to be initiated for their loved one. The completed surveys sighted during audit were very positive about the staff, consent, overall process and staff communication.</p> <p>As an outcome from the NODA programme, monthly palliative care meetings have been introduced from mid-2019 with the introduction of a new palliative care model 'palliative care needs round' which integrates specialist palliative care into Mercy Parkland facility. Team members include the CEO of Mercy Parklands, clinical services manager, a Mercy Hospice representative, a palliative care consultant if required, activities coordinator, chaplaincy and spiritual care representative and nursing staff. These meetings support educating staff to recognize and plan for dying and increase the capacity to care for people in their last months of life. Goals of care are discussed, advanced care plans discussed and reviewed, and hospice and if required specialist palliative care clinical work for residents and families that have complex needs. A debrief of those residents who have died since the last meeting are discussed.</p> <p>Mercy Parklands has seven palliative care link nurses – three of these completed training in September 2019. The palliative care programme at Mercy Parklands includes providing education and support to staff so they</p>
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			<p>can identify residents who are in the last days of life and have a plan in place to provide individualised treatment and care. Staff have more confidence in caring for dying residents and keeping the residents cared for at Mercy Parklands, rather than transferring the resident to the DHB hospital. All resident hospital transfers to Auckland City Hospital have been reviewed and deemed appropriate.</p>
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	<p>CI</p>	<p>The activities programme is provided by the seven members of the activities team, with four staff qualified diversional therapists (DT). Two new members of the team have been employed less than six weeks. The activities programme is developed for a week and readily displayed throughout Mercy Parklands, with the current days programme actively communicated. The activities plan is based on the assessments undertaken of individual residents to ensure the programme provides varied and appropriate activities options for residents based on function, capability and interest. A 'map of life' is used to obtain individualised information from each resident and/or family members with consideration of the resident's interests, function and capability. Activities includes exercises/sit and get fit, arts / crafts, entertainment, pet therapy, puzzles, games, keeping current with news events, music, music therapy, DVDs, church services, and outings where able due to Covid-19 precautions. Special events are celebrated including cultural and faith-based days of significance, and residents' birthdays.</p> <p>The activities programme includes a</p>	<p>In June 2017 Mercy Parklands commenced a project to develop the volunteer programme, with a strong focus on strengthening community and intergenerational allegiances. There are processes in place to ensure volunteers are appropriately selected, orientated and sign confidentiality agreements (refer to 1.2.7).</p> <p>The deputy principal of a nearby School, proposed that year five students, aged 11 and 12 and their teacher, visit residents at Mercy Parklands Hospital to read together and develop meaningful conversation. The Spark of Life and Mercy Parklands values were used to develop this programme. Students have visited the residents each week since 2018 between March through to the end of November (except as required during Covid 19 restrictions). The students through interaction with the residents begin to understand the ageing process and associated medical difficulties, and the residents help students with their reading as part of a formalised reading buddy programme. The shared interactions provided social and physiological benefits for the residents, including decreased depression and anxiety, and giving the residents a greater sense of purpose. A formal survey is conducted annually obtaining feedback from the residents and students on the reading buddy programme and comparing the responses received with the prior year. The responses are very positive. In 2019 the support programs coordinator and lead diversional therapist organised a focus group for the reading buddy recipients before the students started their visits to help in planning how the residents could assist these children. This was identified as an area of improvement from the program evaluation survey. Residents felt valued about the contributions they could make for the young people as part of their future. In addition, students have gained greater understanding of the aging process and at times supported through life's normal processes of grief and loss. Students are recognised at the end of each year with a certificate and afternoon tea celebration. The volunteer/reading buddy</p>

		<p>range of 'clubs' including the 'sunshine club', 'gumnor's club', and other group activities including the walking group, and sensory group. Pet therapy is provided. A complimentary therapy team is comprised of staff working in each hub that provide spontaneous activities with residents including using massage/touch and essential oils. There is a library area on site and a bird aviary. Residents and a family member interviewed confirmed they find the activities programme appropriate and varied, and the activities staff are enthusiastic and patient. Participation is voluntary. Residents also have personal activities that they complete with family or on their own as able. The reading buddy programme and volunteers supporting with resident activities is an area of continuous improvement.</p>	<p>programme was the recipient of the Minister of Health national volunteer award in 2019.</p> <p>Mercy Parklands actively monitors on a monthly basis the number of other volunteers that participate with the activities programme, the number of active volunteers and the number of times volunteers attends and the number of individual contacts with residents and time spent with residents. Formal feedback from residents and family members demonstrate the volunteer programme is an integral part of life at Mercy Parklands, helps the residents retain a sense of being part of a wider community, provides meaningful stimulation and a purpose, and allows residents in the reading buddy programme to contribute to others that gives them dignity and more individualised interactions.</p>
<p>Criterion 1.4.2.6 Consumers are provided with safe and accessible external areas that meet their needs.</p>	<p>CI</p>	<p>A project team was set up in 2018 to develop plans and a construction programme for a looped safe walking and wheeling pathway which was completed in February 2019. Previously the external environment did not support a safe and accessible area to do so. It was identified that while there were other accessible outdoor courtyard areas for residents, the Mercy Parklands garden area was 'prone to being boggy' and needed review. The purpose of the project was to provide a stimulating and purposeful area for residents to walk or be pushed in wheelchairs. This was based on evidence which showed that exercise can slow</p>	<p>Due to a lack of availability of safe and easily accessible external areas for walking on the facility grounds a project team developed a plan, raised funds and implemented the construction of a large loop walkway and wheelchair way for residents. This was completed in February 2019. Evaluation in September 2020 showed that all goals have been achieved and residents, families and staff have benefitted from use of the pathway, and particularly those living with dementia in the hub 2 area. This has resulted in improved mobility, stable health despite their age and diagnosis, increased purpose, independence, verbal communication, satisfaction and reduced falls and agitation for several individuals. Family satisfaction surveys also indicated a high level of satisfaction in this area.</p>

		<p>cognitive decline, improve memory, heart health, mobility, strength, self-esteem, mood, social interaction sleep and reduce agitation. For those in wheelchairs accessing external surrounding provides sensory, cognitive and social stimulation.</p> <p>The walkway is safe and appropriate for residents to walk and be in wheelchairs to go for a walk with families or care staff. The design principals ensure the pathway is non-slip and the surface has no glare whether wet or dry. The garden has been planted to stimulate senses with different varieties of plants based on colour, smell, textures, and to encourage local birdlife with the boggy area becoming a wetland. The pathway and gazebo are used for group and individual activities including the walking group. The pet therapy and family dogs also are taken on these walks with residents, thus developing a sense of purpose. A regular walking group is held weekly around the walkway (weather permitting).</p> <p>An evaluation in September 2020, identified that in the 20 months since the pathway was completed, eight out of the 13 residents in hub two (the dementia enabling household) are able to regularly walk the path as part of household activities. Another regular walking group of on average 10 residents also walk weekly around the path. Identified improvements have included increased resident mobility, more time spent outside, and improved mood/outlook. The interaction with the environment has prompted increased verbalisation of</p>	
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		memories for some residents, and increased vocalisation/communication. The relative satisfaction survey (December 2019), contained positive feedback from family members about the 'accessible' grounds, 'wonderful courtyard and garden walk' that is 'a wonderful place to sit and walk'.	
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End of the report.