

Heritage Healthcare Limited - Karetu House

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 Q-Audit 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: Heritage Healthcare Limited

Premises audited: Karetu House

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 18 July 2019 End date: 19 July 2019

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: 42

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

General overview of the audit

Karetu House is owned and operated by Heritage Healthcare Limited which owns three facilities. The facility was purpose built and is privately owned. The home provides rest home level care to a maximum of 43 occupants. The facility manager and the clinical manager were available for this audit and both are experienced in this sector. The service is unique for providing care and support to residents who require significant additional input from the community mental health services. All the residents, a family member and the general practitioner interviewed reported satisfaction for the care and services provided.

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

The manager reported there have been no changes to size or scope of the service.

There were no areas identified as requiring improvement. One area of continuous improvement was made in relation to good practice.

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> |
|---|--|--|

Staff demonstrate knowledge, understanding and how to implement the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) into all aspects of service provision. The residents receive an information pack on admission and are informed of their rights throughout their stay at this home. Copies of the Code of Rights are displayed in poster form and are available in brochures inclusive of the Nationwide Advocacy Service information available at reception.

Residents, family/whanau receive services that provide dignity, respect and privacy and maximise independence. Ethnic, cultural, spiritual and values and beliefs are respected. Residents who identify as Maori have their individual cultural values and beliefs included in the care plans.

Residents have access to visitors of their choice and are supported to access community services. The service has strong links to community mental health services due to the nature of this service. Advance directives were in place where residents were competent to make own decisions.

Evidence was observed of informed consent and open disclosure in the residents' record reviewed. Interpreter services are accessible if required.

The complaints management system is effective. Complaints are resolved promptly and effectively. A complaints register is maintained by the facility manager. Residents and their families were well informed about how to raise concerns. The manager advised there have been no external complaints received since the previous audit and Section 31 Notifications have been made to appropriate agencies.

Organisational management

| | | |
|---|--|--|
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. | | Standards applicable to this service fully attained. |
|---|--|--|

The organisations has well established quality and risk management systems which monitor service performance. This occurs through internal audits, analysing quality data gathered from event reporting such as incidents, restraints and infections and through resident and relative feedback. Where these activities identify that improvements are required, managers and staff determine the best course of action to resolve the matter. Any gaps in service delivery are monitored by re-auditing to test that improvement has occurred.

All incidents and accidents are reported verbally and in written form and entered on the electronic system. These are reviewed and investigated for cause by the facility manager and the clinical manager who oversees all the clinical care in the facility. Staff act in an open and frank manner by acknowledging what has occurred and notifying senior staff, families or the GP depending on the nature of the incident as soon as practicable. The facility and clinical managers understand about essential notification reporting to appropriate agencies.

The service recruits and manages staff using good employment practices. There is a dedicated workforce who are supported to carry out their roles by in service training and industry education in the provision of safe and appropriate care, food, cleaning and laundry services.

The number of registered nurses, care staff and allied staff on duty for each shift meets safe staffing guidelines and the contract requirements for the level of care provided. The clinical manager and the RN are employed to oversee clinical care and to complete interRAI assessments. There is an after-hours on-call system in place.

Residents' information is accurately recorded, securely stored and is 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. | | Standards applicable to this service fully attained. |
|--|--|--|

The clinical manager (CM) and registered nurse (RN) are responsible for the development of care plans with input from the residents, staff and family member representatives. Care plans and assessments are developed and evaluated according to policy and contractual requirements.

Planned activities provide residents with a variety of individual and group activities. Activities reflect residents' goals and ordinary patterns of life and maintains their links with the community. Residents and a family member expressed satisfaction with the activities programme in place.

There is a medication management system in place and medication is administered by staff with current medication competencies. All medications are reviewed by the general practitioner (GP) every three months or when required.

Nutritional needs are provided in line with nutritional guidelines and residents with special dietary needs are catered for.

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. |
|--|--|--|

Waste and hazardous materials are managed safely. The interior and exterior of the facility is well maintained. A current building warrant of fitness is on display. Medical and electrical equipment is tested and serviced regularly. Fire suppression systems are in

place and checked as functional by an external contractor. Staff are trained in health and safety and managing emergencies including fire by attending trial fire evacuations.

There is a nurse call bell system in place. Security is maintained by staff on all shifts.

Residents bedrooms, bathrooms and communal areas used for dining and recreation are spacious and comfortable. There is a mixture of single and shared rooms with amenities to facilitate independence. Furniture provided is suitable for the care setting. External areas are accessible, safe and provide shade and seating.

All areas are cleaned daily. Laundry services are effective and hygienic.

The home is maintained at a warm and comfortable temperature. All areas have opening doors and windows for ventilation.

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. |
|---|---|--|

The clinical manager is the restraint coordinator. The organisation has policies and procedures that support the minimisation of restraint. Ongoing restraint and challenging behaviour training are provided. There were no residents using enablers nor restraint at the time of the audit.

Infection prevention and control

| | | |
|--|--|---|
| <p>Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.</p> | | <p>Standards applicable to this service fully attained.</p> |
|--|--|---|

The infection prevention and control management system are undertaken by the infection control coordinator (ICC) and aims to prevent and manage infections. The ICC is responsible for coordinating education and training of staff. The infection prevention and control programme are reviewed annually, and specialist advice is accessed when needed. Infection data is collated monthly, analysed and reported during staff meetings. The infection prevention and control surveillance and associated activities are appropriate for the size and complexity of the service. Surveillance for infection is carried out as specified in the infection prevention and control programme.

Summary of attainment

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

| Attainment Rating | Continuous Improvement (CI) | Fully Attained (FA) | Partially Attained Negligible Risk (PA Negligible) | Partially Attained Low Risk (PA Low) | Partially Attained Moderate Risk (PA Moderate) | Partially Attained High Risk (PA High) | Partially Attained Critical Risk (PA Critical) |
|-------------------|-----------------------------|---------------------|--|--------------------------------------|--|--|--|
| Standards | 1 | 44 | 0 | 0 | 0 | 0 | 0 |
| Criteria | 1 | 92 | 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>Staff interviewed had a good knowledge of the Code of Health and Disability Services Consumers' Rights (the Code) and were observed demonstrating respectful communication, encouraging independence, providing options and maintaining dignity and privacy as needed. Information on the Code is included in staff orientation and in the education programme reviewed.</p> <p>The residents reported that they are treated with respect and understood their rights. The general practitioner (GP) interviewed spoke highly of the residents being treated with respect and dignity by staff.</p> |
| <p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p> | FA | <p>The FM, clinical manager (CM) and registered nurse interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant information for staff. There is a generic consent form signed on admission by the resident, next of kin and/or enduring power of attorney (EPOA). There are additional specific forms for other medical procedures such as for the influenza vaccination administered annually. A copy is retained in the resident's record. Staff were observed to obtain consent for day-to-day care. Choices were provided when developing the care plan. There is no evidence of any advance directives in the records reviewed.</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> | <p>FA</p> | <p>All residents are provided with a copy of the Code which also has the information about the advocacy service. Posters and brochures are readily available related to the Nationwide Advocacy Service. Family/guardians interviewed were aware of the advocacy service and how to access this if required. Residents have a right to have support persons of their choice. Training is provided annually to all staff.</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> | <p>FA</p> | <p>Residents are assisted to maximise their potential to maintain links with their family/whānau and the community. The diversional therapist (DT) interviewed provides a programme with outings to the community. The serviced provider has links with other facilities in their group, local schools, marae and community activity services. For the under 65-year-old residents the DT ensures outings to the community are specifically relevant to the individual residents as reflected in their individual activities plans. Family interviewed stated they were able to visit at any time and felt welcomed by the staff.</p> |
| <p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p> | <p>FA</p> | <p>The complaints policy and procedures meet the requirements of this standard, the provider's contract with the DHB, and Right 10 of the Code. It also contains references to advocacy and the organisation's quality system, resident's rights, advocacy and resident/family meetings policies.</p> <p>Review of the complaints register and interview with the FM confirmed there have been no complaints received and managed since the previous audit. There have been no complaints received from external sources such as the Health and Disability Commissioner's (HDC) office since the previous audit. Section 32 notices have been submitted for police investigations (non-substantiated), and one Coroners case open at the previous audit was now closed out. There is one coroner's case which is partially closed out which remains in progress.</p> <p>Systems are in place to ensure residents and their families are advised on entry to the facility of the complaint processes and the Code. The residents and relatives interviewed demonstrated an understanding and awareness of complaint processes. Staff attend regular education on the Code of Rights, including the complaints processes. Review of resident meeting minutes provides evidence of discussion on the Code of Rights and complaints.</p> |
| <p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of</p> | <p>FA</p> | <p>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices. Staff were observed to maintain privacy throughout the audit. All residents have a single room or share a room with consent. Independence is maximised as much as</p> |

| | | |
|--|-----------|--|
| <p>their rights.</p> | | <p>possible due to the nature of this service. Information on the Code and advocacy services is displayed throughout the facility and is available in poster and brochure formats and can be accessed in different languages. A list of advocates and the relevant contact details is readily available.</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>There are policies to guide staff in relation to maintaining privacy and dignity and a policy on elder abuse and neglect. The designated shared rooms have dividing curtains between the beds for visual privacy. The facility manager (FM) is the privacy officer for the facility and deals with any concerns or complaints about privacy being breached.</p> <p>Staff were observed to maintain privacy throughout the audit. Records reviewed confirmed that each residents' individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan. Advance directives were in place if residents were capable of making their own decisions.</p> <p>Staff understood the policy on abuse and neglect including what to do and who to report to should there be any signs. Education is provided to staff.</p> <p>Residents did not express any concerns regarding abuse, neglect, discrimination or breaches of privacy.</p> |
| <p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p> | <p>FA</p> | <p>The service has five residents and two staff who identify as Maori. The organisation has comprehensive policies in relation to information about Maori beliefs in relation to illness, the Te whare tapa wha model of health and an outline of cultural belief experiences in relation to health in the context of Aotearoa New Zealand. The service has a Maori health plan in place which was reviewed. A cultural team is available to the organisation for advice and education as needed. The individual cultural values and beliefs are identified in the care plan. Staff interviewed demonstrated knowledge of individual resident and whanau values and beliefs and the significance of whanau involvement if possible. Many of the residents do not have close whanau due their individual circumstances.</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,</p> | <p>FA</p> | <p>There is a cultural safety policy to guide staff. The resident's individual values and beliefs are recorded in the care plans reviewed including culture and sexual/gender identity. The plans also identify the variety of beliefs that the person may express during psychotic events and how strategies to manage these if they should arise. The resident records evidenced the interRAI assessments and care plans were developed with the resident and family/whanau where relevant. The family members interviewed reported the service more than meets the individual needs of their relatives. Interpreters are used when required. There are residents and staff of varying backgrounds at this service.</p> |

| | | |
|--|----|---|
| cultural, spiritual values, and beliefs. | | |
| Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Residents and family/whanau members stated that residents were free from any type of discrimination, harassment or exploitation. All staff interviewed are fully aware of maintaining professional boundaries and this is included in training and in the individual employment agreements sited. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow. |
| Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard. | CI | <p>The service encourages and promotes good practice through its effective communication with external agencies and the mental health team in the community and at the SDHB. Input is obtained on a referral basis to allied health professionals and/or social services as soon as needed for a resident. Community engagement for residents is important to them and there are no barriers on linking residents with the community. Safety is promoted at all times. The general practitioner interviewed confirmed the service sought prompt and appropriate medical intervention when required and staff were responsive to medical requests. Staff reported they receive management support for external education and access to their own professional networks to support contemporary good practice.</p> <p>In January 2018 it was noted that due to Karetu's ever evolving dynamic with 33 incidents occurring over the previous year involving alcohol consumption by residents a continuous quality improvement was considered and a plan was developed and implemented by the improvement team. A continuous improvement has been awarded to this service for providing an evidenced based project for a pivotal situation which has resulted in a positive outcome for this service and the residents.</p> |
| Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents and family are kept well informed about any changes to their relative's health status or if any incidents or accidents have occurred. This was supported in residents' records reviewed. The monthly resident's meeting provides an opportunity for bringing up any issues. Minutes of meetings were reviewed. Staff understood the principles of open disclosure. The GP interviewed provided positive comments in respect of communication with staff inclusive of the clinical and facility managers. Interpreter services are accessible and can be arranged with the ADHB if required. Advisors and in-house interpreters are available. |
| Standard 1.2.1: Governance | FA | The Karetu House business plan 2019 – 2020 is developed and implemented. The business plan outlines the commitment, the mission statement, values and scope of business. Goals are clearly documented. The |

| | | |
|--|-----------|--|
| <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p> | | <p>plan is realistic, achievable and workable for the size of this service. The service has a majority of residents at rest home level of care who also have identified mental health issues. The service caters for and recognises the needs of a significant range of ages, gender mix and cognitive needs of the residents which can be challenging at times.</p> <p>Karetu House is owned by Heritage Healthcare Limited and is a family owned and operated company. Karetu House provides care for up to 43 residents (rest home level care). On the day of audit 42 beds were occupied. There are nine residents under 65 years of age. Eight of the nine residents under 65 years were under the district health board (DHB) long term chronic health care (LTCHC) agreement with the DHB. Respite care is provided. The facility manager (FM) is an experienced manager with over ten years managing this service in this role. The facility manager has a health and mental health services background and reports regularly to the owner/director. The FM attends forums at the ADHB quarterly and two monthly cluster meetings held at various facilities in this region related to management of aged care services. The FM also gains regular updates from an aged care association on current issues and direction in aged care. The day to day clinical operations are overseen by a clinical manager who is a registered nurse (RN) with a current practising certificate. Staff meetings are held monthly and the monthly meeting form and agenda were reviewed.</p> <p>The clinical manager (CM) has recently been appointed to this role (HealthCERT has been advised). The CM has worked previously as a senior registered nurse at this facility and has work experience in the aged care sector and attends industry specific training to maintain the skills and knowledge required for the ARCC. The clinical manager oversees the care provided to residents with the assistance of two registered nurses</p> <p>One registered nurse on site is currently certified to complete InterRAI assessments and is maintaining the annual competency with this. The organisation has two other facilities and registered nurses competent with interRAI are able to assist with the assessments as needed. There are four registered nurses in total in this organisation who are fully trained and interRAI competent.</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</p> | <p>FA</p> | <p>When the FM is absent the CM is available to cover and is able to carry out all required duties under delegated authority. The owner/director is always available to assist the CM as required. During absences of the CM, the clinical management is overseen by one of the registered nurses who are experienced in the sector and are able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well.</p> |

| | | |
|--|----|--|
| services to consumers. | | |
| <p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p> | FA | <p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities (the audit schedule was reviewed) monitoring of outcomes, clinical incidents including any infections. Quality and risk activities were integrated and co-ordinated for this rest home.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the quality/staff meetings. Relevant corrective actions are developed and implemented to address any shortfalls. In other areas of day to day service delivery, corrective action plans were developed where the need for service improvements were identified and are reported at the quality committee meetings. The meeting minutes confirm that actions were monitored for implementation and effectiveness before being closed off. A monthly narrative and statistical report on quality and risk matters was confirmed by sighting the minutes of meetings. Minutes from staff meetings showed that discussion and reporting on incidents, infections, safety and restraint matters occurs. All staff interviewed clearly understood the service approach to quality and risk.</p> <p>Risk management and occupational health and safety processes were clearly described. The risk management plan was updated annually and identifies all actual and potential business and environmental risks. The sighted hazard register was being maintained and regular environmental inspections were occurring. Residents were being regularly risk assessed using a range of assessment tools including the interRAI assessment tool. The planning and preparedness for emergencies was reviewed.</p> <p>At first stage audit and review of policies and procedures confirmed that policy documents are current and cite best practice. The documents are reviewed annually or earlier if required and are controlled in ways to ensure that only the most up to date version is available. Obsolete documents are managed appropriately. A quality system index is maintained, and manuals are available to guide staff. All new documents are reviewed and authorised by the owner/director.</p> <p>Staff are provided regular education of health and safety matters and are supported in the workplace to keep themselves free from injury. The FM is familiar with the Health and Safety at Work Act (2015) and has implemented the requirements. There had been no staff injuries that required reporting to Work safe.</p> |
| <p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are</p> | FA | <p>The adverse event reporting system was a planned and co-ordinated process. Staff document all adverse, unplanned or untoward events on incident forms. These were reported verbally at handover and in the written summary. Incidents are reviewed by the CM and the FM who document follow up actions. A summary of categorised events is submitted to the FM who reports these to the owner/director monthly.</p> |

| | | |
|---|-----------|---|
| <p>systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p> | | <p>There was evidence in the sample of records reviewed and by interviews that the GP and staff understand and implement open disclosure practices by acknowledging and notifying events to all relevant parties (for example, relatives and the GP).</p> <p>The FM described essential notification reporting requirements including for any pressure injuries. The FM stated there have been there was one coroner's case that was open at the previous audit which has since been closed out effectively. One coroner case this year which is being finalised currently between the DHB and the Coroner's office (a death certificate has now been provided) for the resident is still ongoing. Four cases involving the New Zealand Police with no consequences and all low alcohol events have been reported.</p> <p>As part of the pre-audit, feedback was sought from the DHB and no issues were raised.</p> |
| <p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p> | <p>FA</p> | <p>Human resources policies and guidelines for recruitment and staff management comply with legislation and good employment practices. Professional qualifications are validated before commencement of employment. Copies of the RN's current practising certificates were seen on files. New staff were being recruited according to good employment practices which includes formal interviews, police checking and referee checks. Evidence was sighted in all five personnel records reviewed. The FM and CM have developed and implemented a schedule (sighted) to ensure all appraisals are completed annually as required by the ARC contract.</p> <p>Each new staff member engages in a comprehensive orientation programme specific to their role. The programme includes mandatory training and competency assessments in emergency systems. Staff reported that the orientation and induction gave them a good understanding of their role and responsibilities.</p> <p>Staff learning and development is planned by the clinical manager. The education programme was reviewed. In -service sessions on a range of different topics are scheduled over the year and individual attendance and achievements are documented. All staff have completed first aid and cardio-pulmonary resuscitation on the 18 March 2019. A running record of training attended, and the educational level of each caregiver is recorded. The service also accesses ongoing educational support from the ADHB. The activities coordinator is a diversional therapist and has completed level 4. All care staff are experienced and have completed a New Zealand Qualification Authority (NZQA) education programme to meet the requirements of the provider's agreement with the ADHB. There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments within the organisation. The FM and CM have completed the interRAI management course. Records reviewed demonstrated completion of the required training. Staff who are authorised to administer medicines were being competency assessed annually.</p> |

| | | |
|--|----|--|
| | | |
| <p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p> | FA | <p>There is a documented policy on staff numbers and skill mix which has been implemented for determining staffing levels and skill mix to provide safe service delivery. The policy describes the service approach to staffing the facility 24 hours a day seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. An after-hours on call roster is in place with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Observation and review of four-week rosters confirmed adequate cover has been provided with staff replaced in any unplanned absences. All staff have been trained in first aid as per the training records.</p> <p>The sample of rosters for 2019, and interview with the FM, clinical and care staff, residents and families, confirmed there were sufficient numbers of staff on each duty to meet resident's needs. Care staff interviewed stated they are offered extra hours when residents needs change. There are adequate care staff allocated to cover the number of residents on each shift.</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> | FA | <p>All necessary demographic, personal, clinical and health information was fully completed in the residents' records sampled for review. Clinical records were current and integrated with general practitioner and allied health service provider records. This includes interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using an appropriate archiving system. Residents' records are held for the required period before being destroyed. No personal or 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 competent, equitable, timely, and respectful manner, when their need for services has been identified.</p> | FA | <p>The entry to service policy includes all the required aspects on the management of enquiries and entry. The information pack contains all the information about entry to the service. A pre-entry screen is completed on all potential referrals, and if Karetu House is unable to accommodate the consumer then the referrer, client and family/whanau are notified at the first opportunity, and an alternative referral is made as required. It is Karetu House's policy that all referrals are treated within the framework of the Human Rights legislation.</p> <p>Records sampled confirmed that admission requirements are conducted within the required time frames and signed on entry. The admission agreement clearly outlines services provided as part of the agreement</p> |

| | | |
|---|----|--|
| | | to entry. Relatives interviewed confirmed that they received sufficient information regarding the services to be provided. |
| <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> | FA | <p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort. 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. At the time of transition, appropriate information is provided to the person/facility responsible for the ongoing management of the resident. All referrals are recorded in the progress notes.</p> |
| <p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p> | FA | <p>The medication management system is implemented to ensure that residents receive medicines in a secure and timely manner that meets current legislation, protocols and guidelines. A paper-based management system is used in administration, reviewing, and prescribing. The service uses a pre-packed medication system. All medication packs are checked by the CM on delivery against medication charts every month. Medicines held in stock are checked every month and any expired medicines are returned to the pharmacy promptly. GP conducts three monthly reviews of medication charts.</p> <p>Controlled drugs are stored securely in accordance with legislative requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidenced weekly and six-monthly stock checks. Medication is safely stored in locked cupboards and drug trolley. There were no expired medications on site. Two health care assistants were observed administering medication correctly in their respective wings. All staff who administer medicines were assessed as competent and evidence was sighted. There were residents who self-administer lotions and creams and were assessed as competent. Regular monitoring is conducted, and care plans updated. Medication audit was conducted on 10 January 2019 and corrective actions were acted upon.</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> | FA | <p>Meal services are prepared on site and served in the allocated dining room and residents' rooms as required. The service employs cooks who work from Monday to Sunday. The menu has been reviewed by a registered dietitian to confirm it is appropriate to the nutritional needs of the residents. There is a four weekly rotating winter and summer menu in place. Hot, cold drinks and snacks are provided for throughout the day and night when needed.</p> <p>The residents have a nutritional profile developed on admission which identifies dietary requirements, likes and dislikes and is communicated to the kitchen including any recent changes made. Diets are modified as required and the cook confirmed awareness on dietary needs required by the residents. Meals are served warm in sizeable portions required by residents and any alternatives are offered as required. The residents'</p> |

| | | |
|--|----|---|
| | | <p>weights are monitored monthly and supplements are provided to residents with identified weight loss issues.</p> <p>The kitchen and pantry were clean, tidy and stocked. Labels and dates are on all containers and records of food temperature monitoring, fridges and freezers temperatures are maintained. Regular cleaning is conducted. The food service was registered under the new food control plan. It was audited by the local council on 24 April 2019 and attained food safety grade A. Menu audit was conducted and results were acted upon.</p> <p>The residents and family interviewed confirmed satisfaction with the food service.</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>There is a documented policy on decline of entry to the service. Where a potential consumer is declined entry and a meeting is arranged. The reason/s for declining entry is communicated in a timely manner. Where requested, assistance is given to provide the consumer and their family with other options for alternative health care arrangements or residential services. The consumer's details will be recorded into the Resident Register.</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>All referrals to Karetu House are assessed by the clinical manager and facility manager (FM). Residents have their level of care identified through a needs assessment by the Needs Assessment and Service Coordination (NASC) agency prior to admission. The clinical manager utilises standardised assessment tools to collect residents' data in consultation with the resident and their relatives where appropriate. Files sampled contained appropriate completed assessment tools and interRAI assessments were reviewed at least six monthly or when there is a change to a resident's health condition. Cultural, sexuality and intimacy needs are identified, and additional assessments are completed according to the need such as nutritional, continence and pressure assessments. The information gathered is documented and informs the initial care planning process. Data collection is conducted in the resident's bedroom to maintain privacy.</p> <p>A medical assessment is undertaken within five days of admission and medical reviews are completed when resident's condition changes, or three monthly when they are assessed as stable.</p> |
| <p>Standard 1.3.5: Planning</p> | FA | <p>Care plans are resident focussed, integrated and provide continuity of service delivery. The assessed</p> |

| | | |
|---|-----------|--|
| <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p> | | <p>information is used to generate long term care plans and short-term care plans for acute needs. Goals are specific and measurable, and interventions are detailed to address the desired goals/outcomes identified during the assessment process. Care plans sampled were integrated and included input from the multidisciplinary team. The residents and relatives interviewed confirmed care delivery and support is consistent with their expectations and plan of care.</p> |
| <p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p> | <p>FA</p> | <p>Documentation, observations and interviews verified the provision of care provided to residents met assessed needs and desired goals/outcomes. Significant changes are reported in a timely manner and prescribed orders carried out satisfactorily as confirmed by the GP in the interview conducted. Progress notes are completed every shift by the health care assistants and weekly or where required by the clinical manager. Monthly observations are completed and are up to date. A range of equipment and resources were available, suited to the level of care provided and in accordance with the residents' needs. Staff confirmed they have access to the supplies and products they needed.</p> |
| <p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p> | <p>FA</p> | <p>Activities are planned by the diversional therapist (DT) in consultation with the clinical manager and facility manager respectively. The DT works three days a week and other days are filled in by health care assistants and volunteers. A monthly planner is posted on the notice boards that are accessible to residents and they are individually reminded every morning. Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Residents and their family/whanau are consulted in the activities assessment and planning process. There is a wide range of activities offered, including: bingo; quiz; music sessions; walking groups; Tia chia, memory games; gardening and housie. External entertainers are invited, church, mobile library and music groups. Van outings are conducted twice a week to areas of interest. Attendance is noted on handover sheets. The residents' activities needs are evaluated by the DT in consultation with the clinical manager and the RN who completes interRAI assessments six-monthly.</p> <p>Monthly residents' meetings are conducted, and outcomes are implemented and communicated to family/whanau and residents. A newsletter is published every month and is given to residents and family/whanau. Monthly DT support groups are conducted and involves personnel from other facilities. Interviewed residents and family members reported satisfaction with the activities programme. Residents were observed participating in a variety of activities on the days of the audit.</p> |
| <p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery</p> | <p>FA</p> | <p>Residents' long-term care plans, interRAI assessments and activity plans are evaluated at least every six months and updated when there are any changes. Family/whanau, residents and staff are consulted in the</p> |

| | | |
|---|-----------|--|
| <p>plans are evaluated in a comprehensive and timely manner.</p> | | <p>review process. The evaluations record how the resident is progressing towards meeting their goals and responses to interventions. Short term care plans are developed when needed, signed and closed out when the short-term problem has resolved.</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 consumer choice/needs.</p> | <p>FA</p> | <p>There is a documented process for the management of all referrals. Residents are supported to access or seek referral to other health and/ or disability service providers. The service utilises a standard referral form when referring residents to other service providers. Copies of referrals were sighted in residents' files reviewed. The GP confirmed that processes are in place to ensure that all referrals are followed up accordingly. Resident and family are kept informed of the referrals made by the service. All referrals are facilitated by the CM or GP.</p> |
| <p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p> | <p>FA</p> | <p>Policy and procedures contained clear descriptions about disposal methods for all types of hazardous and domestic waste. The policy includes the use of protective clothing and equipment and reporting of spills incidents. A spills kit is available. The laundry and sluice were observed to be in a tidy and hygienic condition. The hazard register was current. Household waste is collected by the local council once a week and the service has a contract with a designated company which collects recycled rubbish every Tuesday and every second Monday. Review of staff training records and interviews with staff who carry out cleaning and laundry duties confirmed that regular training and education on the safe and appropriate handling of products and waste occurs. Visual inspection throughout the facility and observations of staff during both audit days reveals that protective clothing and equipment (for example, gloves, plastic aprons, footwear, and masks) is provided.</p> |
| <p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p> | <p>FA</p> | <p>The physical environment was safe and fit for purpose and well maintained. Handrails were installed in corridors, showers and toilets to promote safe mobilisation. All external areas inspected were safe and surfaces were paving services were level at the rear of the property. Shade sails and umbrellas are available in the summer months or if needed for the external courtyard. A ramp was available, and the front deck was covered and residents were seen to sit out on this area during the day. There was a caring and homely atmosphere observed in the home.</p> <p>Medical equipment such as sphygmomanometer, scales and other equipment were checked and calibrated annually. The biomedical equipment performance verification report was reviewed dated 28</p> |

| | | |
|---|----|---|
| | | <p>November 2018. Electrical testing was completed 23 November 2018. Staff and residents confirmed they knew the processes they should follow if any repairs or maintenance is required. Any request is appropriately actioned by the maintenance personal interviewed.</p> <p>The current Building Warrant of Fitness expires on 15 June 2020 and is framed and displayed at the entrance to the rest home.</p> <p>The residents reported satisfaction with the environment at Karetu House.</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> | FA | <p>There are ten (10) shared rooms with approximately four ensuites. There are 23 bedrooms with no ensuites. All bedrooms have hand basins and are in close proximity to toilets and bathrooms. Inspection of all bathrooms and toilets showed these were in good condition, were accessible with easy to clean walls and floor surfaces. Approved handrails are in place to assist residents with poor mobility and to promote resident independence. Hot water temperatures were monitored monthly and evidenced acceptable temperatures determined by the building regulations 1992 to minimise risk of scalding/burning. Review of the records for 2019 and hand testing at tap sites reveals temperatures are at or below 45 degrees Celsius.</p> <p>There are designated staff/visitor toilets available.</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> | FA | <p>Each of the bedrooms viewed provided space for staff to move freely within their bedrooms safely with plenty of room to accommodate walking aides and other mobility equipment. All residents 'rooms were personalised with furnishings, photos, furniture of their choice and other personal items. There was screening between the beds in the bedrooms being shared. All the beds provided were in good condition.</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> | FA | <p>There is a large lounge/dining area which is used for functions and/or activities the rest home. There is adequate space so lounge, dining and activities do not impact on each other. There is a smaller quiet lounge/whanau room with comfortable seating and a games and other activities are accessible. Residents interviewed said they were very happy with the range of spaces available to them. All furniture is safe and suitable for the consumer group.</p> |

| | | |
|--|-----------|---|
| <p>Standard 1.4.6: Cleaning 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>FA</p> | <p>There is a dedicated cleaner who works three days a week and other rostered staff cover the additional days. The facility is well maintained and is on visual inspection clean and tidy. The laundry duties constitute part of the healthcare assistants' duties. The laundry is designed to maximise efficient and safe work flows and linen handling while minimising any cross contamination. The organisation conducts regular reviews and internal audits of cleaning and laundry services to ensure these are safe and effective. The cleaning schedule was reviewed. The cleaner's trolley is locked away when not in use. Where improvements can be made these are implemented. The FM provides education and ongoing support and information to staff about safe handling of the products in use and reviews the effectiveness of methods and products use. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner.</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>The service is maintaining emergency preparedness and management. The emergency management plan continues to be reviewed and updated to ensure it complies with best known practice and statutory requirements. The emergency resources and equipment are regularly checked. Emergency lighting is available. No generator is available on site but can be hired as needed. Emergency processes are known to staff. There was sufficient food, water and personal supplies stored to provide for the maximum number of residents and carers in the event of a power outage and to meet the requirements of the local council. Food and water stores are inspected and checked off regularly.</p> <p>An agreement also exists with other care facilities in the organisation for transfer of residents if the buildings are uninhabitable. The fire evacuation approval letter from the New Zealand Fire Service (NZFS) reviewed was dated 15 June 1993. The NZFS attends and observes at least one of the six-monthly trial fire evacuations each year. The most recent fire drill occurred on 29 May 2019 with a good staff attendance. Records are maintained. Outcomes and learning from these exercises are documented and used to improve protocols.</p> <p>Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and residents and families reported staff respond in a timely manner.</p> <p>Appropriate security arrangements are in place. Staff check the facility each shift and several times on the afternoon and night shifts. Sensor lights are installed outside the home. There had been no security issues reported.</p> |
| <p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with</p> | <p>FA</p> | <p>The home is centrally heated with two gas units being available. These provide warmth and cooling in the summer in the rest home. The FM confirmed that the heating systems were running smoothly. The home had sufficient doors and external opening windows for ventilation. All bedrooms had good sized external</p> |

| | | |
|---|----|--|
| adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | | opening windows which are designed and installed to be secure. The residents and relatives interviewed confirmed that internal temperatures and ventilation are comfortable during summer and winter months. |
| <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> | FA | <p>The service implements an infection prevention and control programme to minimise the risk of infection to residents, staff and visitors. The CM is the designated infection control coordinator (ICC), whose role and responsibilities are defined in a job description. ICC has access to external specialist advice from a GP and DHB infection control specialists when required.</p> <p>The infection prevention and control programme are reviewed annually and is incorporated in the monthly meetings and a review of the education programme is conducted. Staff are made aware of new infections through daily handovers on each shift and progress notes. The infection control programme is appropriate for the size and complexity of the service.</p> <p>There are processes in place to isolate infectious residents when required. Hand sanitisers and gels are available for residents, staff and visitors to use. There have been no outbreaks documented since the last audit and infection control guidelines are adhered to. Staff interviewed demonstrated an understanding of the infection prevention and control 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 ICC has appropriate skills, knowledge and qualifications for the role. The ICC is responsible for implementing the infection control programme and indicated there are adequate human, physical, and information resources to implement the programme. Infection control reports are discussed at the staff meetings. The ICC has access to all relevant resident data to undertake surveillance, internal audits and investigations respectively.</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</p> | FA | <p>The infection prevention and control policies reflect the requirements of the infection prevention and control standards and current accepted good practice. Policies and procedure were reviewed. Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such appropriate use of hand-sanitisers, good hand washing technique and use of disposable aprons and gloves. Hand washing facilities and sanitiser dispensers are readily available around the facility. Staff demonstrated knowledge on the requirements of standard precautions and able to locate policies and procedures.</p> |

| | | |
|--|----|---|
| and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | | |
| Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | Staff education on infection prevention and control is conducted by the ICC and other external specialist consultants. The ICC attended an infection prevention and control training in the previous year. A record of attendance is maintained and was sighted. The training education is detailed and meets best practice and guidelines. Residents are reminded on infection control practices during residents' meetings or as when required. External contact resources include: GP, laboratories and local district health boards. Staff interviewed confirmed an understanding of how to implement infection prevention and control activities into their everyday practice. |
| Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | The infection surveillance programme is appropriate for the size and complexity of the organisation. Infection data is collected, monitored and reviewed monthly. The data is collated and analysed to identify any significant trends or common possible causative factors and action plans are implemented. Quarterly reports are completed and compared with previous year's site infection rates. New infections and any required management plans are discussed at handover, to ensure early interventions occurs. The GP is informed within the required time frame when a resident has an infection and appropriate antibiotics are prescribed to combat the infection respectively. Surveillance programme is reviewed during the infection control programme review. |
| Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised. | FA | 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. Restraint is only used as a last resort and staff receive adequate training to enable them to make informed decisions. All staff receive education regarding restraint minimisation and management of challenging behaviours and latest training was conducted on 11 June 2019 and 14 staff attended. Staff interviewed understood the difference between a restraint and enabler. The service currently has no residents using restraint or enablers. A restraint register is in place if needed. |

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

| Criterion with desired outcome | Attainment Rating | Audit Evidence | Audit Finding |
|--|-------------------|--|---|
| <p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p> | CI | <p>A project was initiated due to a significant increase in incidents occurring due to consumption of alcohol either on site or in the community. This increase in incidents was a significant issue for the service provider as this had not occurred in the past. Discussion and consultation occurred with collaboration of external agencies such as ADHB social work team, mental health services for older persons, NASC, the New Zealand Police alcohol harm prevention team, staff at Karetu, the GP, DT and the Karetu cultural team and other services as applicable. Associated issues included continence issues, hygiene, cleanliness and management of these residents. Anomalies ascertained included residents had access to too much money, non-compliant EPOAs, spousal enabling, co-dependence and personalities of residents. The rights of residents were also taken into consideration at all times. What worked was to develop and implement an alcohol management policy. Restrict finances (no money – no booze), management of the intoxicated resident (monitoring forms were introduced), instigated new rules – no alcohol on the premises, increased education for staff on intoxication</p> | <p>The achievement of this project implementing additional support and services to meet the needs of residents with alcohol related diagnoses is rated beyond the expected full attainment. The service’s approach and philosophy of managing this significant issue addressed gained positive results in the reduction of incidents related to alcoholism, and challenging behaviour due to alcohol. The rights of the resident were upheld though some residents had to be referred to other services. With a culturally appropriate model of care and philosophy improvement was measured through number of incidents, staff, resident, and family satisfaction and improvement in</p> |

| | | | |
|--|--|---------------------------------|--|
| | | and use of a breathyliser unit. | management strategies, health and wellness of residents. |
|--|--|---------------------------------|--|

End of the report.