

# Ohope Beach Care Limited - Ohope Beach Care

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## 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 HealthShare 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:** Ohope Beach Care Limited

**Premises audited:** Ohope Beach Care

**Services audited:** Rest home care (excluding dementia care); Dementia care

**Dates of audit:** Start date: 26 September 2019 End date: 27 September 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:** 32

# Executive summary of the audit

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## 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

Ohope Beach Care Limited, trading as Ohope Beach Care, provides rest home and dementia level care for up to a maximum of 36 residents. Short stay /respite can also be provided subject to bed availability. Day to day operations/service delivery are overseen by a facility manager who reports to a director.

There have been no significant changes to the service since the previous surveillance audit in 2017.

This re-certification audit was conducted against the Health and Disability Services Standards and the service's contract with District Health Board (DHB). The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, the facility manager, staff, and a general practitioner (GP). The GP, residents and families spoke positively about the care provided.

There were no areas identified that required improvement.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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The Health and Disability Commissioner`s Code of Health and Disability Services Consumers` Rights (the Code) is made available to residents and family/whanau on admission. Their privacy, independence and personal safety is protected. Care and support is provided in a manner which recognises the residents' culture, values and beliefs. Residents` who identify as Maori have their needs met in a manner that respects their cultural values and beliefs. Their care is guided by cultural policies. There was no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are understood by staff and maintained. Service delivery is based on good practice principles.

Communication is open and resident choices are recorded and acted upon. Adequately documented processes are in place for informed consent. Residents and family/whanau are assisted and encouraged to formulate advanced directives. Advocacy information is available for residents and family/whanau. Links with family/whanau and the community are encouraged and supported by the service provider. A complaints register is maintained with complaints resolved promptly and effectively.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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An annual strategic plan describes the scope, direction, goals, values and mission statement of the organisation. The directors are monitoring all aspects of the services provided and are on site daily. One director oversees the facility and operational matters and the other director who is an experienced registered nurse oversees residents care and all clinical matters.

The quality and risk management system collects quality data, identifies trends and leads to improvements. Staff are involved, and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery. Policies were current and are reviewed and updated as needed at regular intervals.

The appointment, orientation and management of staff adheres to good employment practices. There is a systematic approach to identifying and delivering ongoing staff training. This supports safe service delivery and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

Residents' information is 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.		Standards applicable to this service fully attained.
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Food services are provided in ways that meet the nutritional needs and preferences of residents. The service has a verified food control plan and all stages of food procurement, preparation, handling and storage meet safe food handling guidelines and legislation.

Residents are assessed by the Needs Assessment Service Co-ordination (NASC) prior to entry to the service to establish a level of care. The processes for assessment, planning, provision, evaluation, review and exit are provided by the registered nurses (RNs). InterRAI assessments and individualised care plans were sighted.

The service provides planned activities that meet the needs and interests of the residents as individuals and in group settings. Twenty-four-hour activity care plans and diversional care plans are in place. There is a medicine management system in place. Three monthly medication reviews are conducted by the general practitioner (GP). The organisation uses an electronic system in e-prescribing, dispensing and administration of medications. Staff involved in medication administration are assessed as competent

## 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.

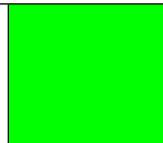
The facility meets the needs of residents and is being kept clean, comfortable and maintained as safe. All equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible and safe for residents' use.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry and cleaning is undertaken by care staff and evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies and they attend regular fire drills. Residents reported a timely staff response to call bells

## 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.

Ohope Beach Care has a philosophy and practice of no restraint. On the days of audit there were no restraints or enablers in use.

Policies and procedures meet the requirements if a restraint is required. Staff education in restraint minimisation is ongoing.

## 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.

The infection control programme is developed in consultation with the relevant key stakeholders. The environment is managed in a way that minimises the risk of infection to residents, staff and visitors. The infection control coordinator (ICC) is responsible for monitoring infections, surveillance of data, trends and implementing relevant strategies. There was an infection outbreak reported and this was managed according to the required standards. Notification to the ministry of health and local district health board were completed in a timely manner.

## 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)
<b>Standards</b>	0	45	0	0	0	0	0
<b>Criteria</b>	0	93	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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>Ohope Beach Care has policies and procedures to meet their obligation in relation to the Code of Health and Disability Services Consumer Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff and ongoing training as verified in the training records.</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>Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files sampled show that informed consent has been gained appropriately using the organisation's standard consent form. These are signed by the enduring power of attorney (EPOA) or residents and the general practitioner makes a clinically based decision on resuscitation authorisation. All files sampled had activated EPOA in the dementia wings. Staff were observed to gain consent for day to day care. Interviews with relatives confirmed the service actively involves them in decisions that affect their family members' lives.</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>As part of the admission process residents and family/whanau are given a copy of the Code, which includes information on advocacy services. Posters and brochures related to the national advocacy service were displayed and available in the facility. Family members interviewed were aware of the advocacy service, how to access this and their right to have support persons. The facility manager and staff provided examples of the involvement of advocacy services in relation to residents' care.</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 to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment. The facility has unrestricted visiting hours and encourages visits from residents' family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their encounters with 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>	FA	<p>Review of documents and interviews confirmed there have been no complaint investigations by the DHB or Office of the Health and Disability Commissioner. The only complaints in the complaint register are from staff about staff. These have been effectively managed according to the information recorded about each matter and interviews with staff and the manager. The residents and family members interviewed confirmed they knew what to do if they had a concern/complaint and said they had no reservations about approaching any staff member to raise these.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Information about the consumer rights legislation, advocacy services and the complaints process are provided on admission and displayed at the reception. The Code is available in Maori and English. Family members and residents interviewed were aware of consumers rights and confirmed that information was provided to them during the admission process.</p> <p>The information pack outlines the services provided. Resident agreements signed either by the residents or by an enduring power of attorney (EPOA) were sighted in records sampled. Service agreements meet the district health board requirements. Bi-monthly residents meeting are conducted.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p>	FA	<p>The residents' privacy and dignity are respected. Staff were observed maintaining privacy. All rooms are single occupancy. Residents in the dementia wings are supported to maintain their independence with the residents able to come and go within the building and around the secure grounds as they</p>

<p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>		<p>please. Residents in the rest home wing can go in and out of the facility with no restrictions. Records sampled 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>There is an abuse and neglect policy and staff interviewed understood how to report such incidents if suspected or observed. The facility manager reported that any allegations of neglect if reported would be taken seriously and immediately followed up. There were no documented incidents of abuse or neglect in the records sampled. The GP reiterated that there was no evidence of any abuse or neglect reported. Family/whanau and residents interviewed expressed no concerns regarding abuse, neglect or culturally unsafe practice.</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 required policies on cultural appropriateness are documented. Policies refer to the Treaty of Waitangi and partnership principles. The Maori Health plan includes a commitment to the principles of the Treaty of Waitangi and identifies barriers to access. It also recognises the importance of whanau. Assessments and care plans document any cultural/spiritual needs. Special consideration to cultural needs is provided in the event of death as described by staff. The required activities and blessings are conducted when and as required. All staff receive cultural awareness training. There were five residents and three staff members who identify as Maori at the time of the audit.</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>	<p>FA</p>	<p>Cultural needs are determined on admission and a care plan is developed to ensure that care and services are delivered in a culturally and/or spiritually sensitive manner in accordance with protocols/guidelines as recognised by the family/whanau. Values and beliefs are discussed and incorporated into the care plan. Family members and residents interviewed confirmed they are encouraged to be involved in the development of the long-term care plans. Residents' personal preferences and special needs were included in care plans sampled.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and residents reported they felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the code of conduct. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation. The facility manager stated that there have been no reported alleged episodes of abuse, neglect or discrimination towards residents.</p>

<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service encourages and promotes good practice through ongoing professional development of staff. Policies and procedures are linked to evidence-based practice. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests. Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice.</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>Family members stated they were kept well informed about any changes to their relative's health 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 sampled. Staff understood the principles of open disclosure, which is supported by policies and procedures.</p> <p>Staff know how to access interpreter services if required. Staff can provide interpretation as and when needed; the use of family members and communication cards is encouraged.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Ohope Beach Care has agreements with the Bay of Plenty District Health Board (DHB) for Aged Related Residential Care and respite/short term care. The facility has a maximum capacity for up to 36 residents, comprising 11 rest home and 25 dementia beds. On the days of the audit there were 32 residents. This comprised of 11 residents requiring rest home level of care and 21 residents requiring dementia care.</p> <p>The business plan is developed and reviewed annually by the owner in consultation with the facility manager. This contains the direction, vision, mission statement, scope of services, objectives and an action plan.</p> <p>The manager submits written reports to the owner monthly. These contain information about occupancy, service delivery issues and highlights, staffing information, maintenance, complaints and compliments, adverse events and internal audit outcomes.</p> <p>Review of the results from the June 2019 satisfaction survey of residents and their families showed increases in satisfaction across a range of services provided in the past 12 months.</p> <p>The service is managed by a facility manager (FM) who is a registered nurse with extensive clinical and managerial experience in age care. This person is suitably qualified with post graduate achievements in leadership and palliative care and is approved as a moderator and assessor for Careerforce (who provide an educational pathway for people working in age care)</p> <p>The clinical coordinator (CC) is an RN who is experienced in providing clinical care for older people.</p>

		The CC and the FM share the same philosophy of person centred care, having both implemented the Eden Alternative Approach to caring for older people. They have implemented a number of new approaches in service delivery. Both are attending ongoing education related to their roles and each has completed at least 8 hours of professional development in the previous year.
<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>	FA	The FM and the CC cover for each other's absences. The FM is involved in the day to day delivery of care to residents and is maintaining her clinical knowledge and skills. When either person is away another fulltime employed senior RN is on site to back fill and provide support.
<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>Review of documents and interview with the facility manager demonstrated the effectiveness of the quality and risk management systems. A documented quality and risk management plan clearly describes the approach to quality and risk and service monitoring processes including regular internal audits. The policies and procedures are industry standardised and align with the Health and Disability Services Standards, legislative or contractual changes.</p> <p>Quality data, such as incidents/accidents, infections, skin tears, falls, results of internal audits, complaints and service delivery improvements are analysed and discussed with all levels of staff at weekly and monthly meetings. There is evidence of actions being implemented to good effect when service deficits are identified.</p> <p>A number of quality improvements have been actioned since the previous surveillance audit in June 2018. Examples include the establishment of new processes for staff hand over, virtual separation of the secure unit into two 'pods' to reduce noise levels and stimulation, protocols for preventing weight loss in residents and other initiatives which demonstrate a commitment to quality improvement.</p> <p>Residents and family members interviewed confirmed they are consulted about services and are kept updated through regular group and/or one to one meetings and via the service newsletters.</p> <p>The organisation's quality and risk management plan and associated emergency plans, identify current actual and potential risk to the business, service delivery, staff and/or visitors' health and safety. Environmental risks are communicated to visitors, staff and residents verbally or by signs. The audit team were provided with a health and safety briefing upon arrival. Review of a range of staff meeting minutes showed that health and safety, including new hazards and resident related risks, are</p>

		discussed. The organisation has achieved bronze level and are progressing toward silver level with the Bay of Plenty DHBs 'Workwell-Silver Standard Accreditation' program. This program provides a comprehensive and practical approach to health and safety in the workplace.
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>The sample of event records reviewed contained a clear account of the event, actions taken at the time and any ongoing actions, for example neurological observations after a fall and where changes had been made to prevent or minimise recurrence.</p> <p>Records showed that staff, families, the GP, district health board or others who are impacted by an adverse event, are informed in a timely manner. Trends in adverse events are being monitored and reported back to staff and the owner at regular intervals.</p> <p>Section 31 notifications were submitted to the Ministry of Health and the DHB Public Health in June 2019 regarding an outbreak of Influenza A.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. A new RN and a new cleaner interviewed said the orientation process was preparing them well for their role.</p> <p>Documents and interviews confirmed that a site-specific training plan is developed each year which includes mandatory training requirements. Review of the 2018 to 2019 plan and attendance records confirmed that staff are being provided with continuing education in subjects related to age care. A record of each staff member's training is recorded in their personnel files and is reviewed with them during their performance appraisals.</p> <p>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. All of the 23 caregivers are engaged with an educational pathway with Careerforce or have already achieved unit standards in care of older people. On the days of audit, six had achieved level 4, eight were on level 3, eight on level 2 and five on level 1 qualifications. Review of rosters and staff files confirmed that the RNs and all carers who work in the dementia unit have either attained or are progressing toward attaining the level four dementia qualification. Three registered nurses are trained and are maintaining their annual competency requirements to undertake InterRAI assessments and the FM has management access to the system. The facility manager is experienced with providing staff</p>

		<p>education in the age care sector and has been confirmed as a Careerforce moderator.</p> <p>The six staff records reviewed contained evidence of annual performance appraisals being completed in 2019.</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 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). Staffing levels are adjusted to meet the changing needs of residents. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. All staff members are maintaining a current first aid certificate and there is 24 hour/seven days a week (24//7) RN on call. Only staff who have completed or are progressing educational achievements in dementia care (US 23920-23923) are rostered for duties in the secure unit.</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>A resident register is maintained of all current and past residents. Resident individual information is kept in paper format. The resident's name, date of birth and National Health Index (NHI) number are used as the unique identifier on all residents' information. All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled. Clinical notes were current and integrated with GP and allied health service provider notes. Written records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on and off site and are readily retrievable using a cataloguing system. Residents' files 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. Ohope Beach Care's welcome pack contains all the information about entry to the service. Assessments and entry screening processes are documented and clearly communicated to the family/whanau of choice where appropriate, local communities and referral agencies.</p> <p>Records sampled confirmed that admission requirements are conducted within the required time frames and are signed on entry. Family/whanau interviewed confirmed that they received sufficient information regarding the services to be provided.</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>There is a documented process for the management of transfers and discharges. A standard transfer form notification from the DHB is utilised when residents are required to be transferred to the public hospital or another service. Residents and their families are involved in all exit or discharges to and from the service and there was sufficient evidence in the residents' records to confirm this.</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 identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. A safe medication management system was observed. Indications for use are noted on 'as required' medications, allergies are clearly indicated and photos are current. Administration records are maintained, and drug incident forms are completed in the event of any drug errors. All medicines are reviewed every three months and as required by the GP.</p> <p>A registered nurse was observed administering medications safely and correctly. The medication and associated documentation are in place. Outcomes of pro re nata (PRN) are documented. Medication reconciliation is conducted by the RNs or FM when a resident is transferred back to service. The RNs checks medicines against the prescription. There were no expired or unwanted medicines and expired medicines are returned to the pharmacy in a timely manner. There were no residents self-administering medications and there is self-administering policy in place if required. The controlled drug register is current and correct. Weekly and six-monthly stock takes were conducted, and this was confirmed on previous entries.</p> <p>Monitoring of medicine fridge temperatures is conducted regularly and deviations from normal are reported and attended to promptly. The service does not keep any vaccines.</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>Meals are prepared on site and served to residents in their separate (rest home and secure unit dining rooms). The service employs a sufficient number of cooks for the tasks required seven days a week. All kitchen staff have completed training in food safety/hygiene. The menu was reviewed by the registered dietitian in 2019. Diets are modified as required and the cook confirmed awareness of dietary needs of the residents.</p> <p>Observation of meal times in the secure unit on the days of audit, revealed that those residents who need assistance with eating and drinking are ably supported 1:1 by enough staff. Residents were unhurried in a calm atmosphere. Fluids and snacks were being provided regularly outside of meal times. The meals are served warm in sizeable portions as required by residents and alternatives were offered where required. The residents' weights are monitored monthly and supplements are</p>

		<p>provided to residents with identified weight loss issues. Staff interviews and records provided evidence that a recently seriously unwell resident had fully recovered following administration of hourly fluids.</p> <p>Residents and family/whanau interviewed expressed high satisfaction with the meals and food supplied.</p> <p>The food control plan has been verified by an external agency in 2019. All areas in the kitchen and pantry were observed to be clean, tidy and stocked. Labels and dates are on all decanted food containers. Records of food temperature monitoring, fridges and freezers temperatures are being maintained.</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>The FM reported that all consumers who are declined entry are recorded on the resident refused entry form and when entry is declined relatives are informed of the reason for this and made aware of other options or alternative services available. The consumer is referred to the referral agency to ensure that the resident will be admitted to the appropriate service provider.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Residents have their level of care identified through needs assessment by NASC agency. Initial assessments were completed within the required time frame on admission while resident care plans and interRAI are completed within three weeks according to policy. Assessments and care plans are detailed and include input from the family/whanau and other health team members as appropriate. Additional assessments were completed according to the need, for example, behavioural, nutritional, continence, skin and pressure assessments. The nursing staff utilise standardised risk assessment tools on admission. In interviews conducted family/whanau expressed satisfaction with the assessment process.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>The assessment findings in consultation with the resident and/or family/whanau, informs the care plan and assists in identifying the required support to meet residents' goals and desired outcomes. The care plans sampled were resident focused and individualised. Problem/short term care plans were used for short-term needs. The individual behaviour management plans specify prevention-based strategies for minimising episodes of challenging behaviours and describe how the residents' behaviour is best managed over a 24-hour period. Family/whanau interviewed confirmed they were involved in the care planning process. Resident files demonstrated service integration and evidence</p>

		of allied healthcare professionals involved in the care of the resident such as the mental health services for older people, palliative and district nurses, dietitian and GP.
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	Interventions are adequate to address identified needs in the care plans. Significant changes are reported in a timely manner and prescribed orders carried out satisfactorily as confirmed by the GP. The GP reported that medical input is sought in a timely manner, that medical orders are followed, and care is person centred. Health care assistants confirmed that care was provided as outlined in the care plan. A range of equipment and resources were available, suited to the level of care provided and in accordance with the residents' needs.
<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>	FA	<p>The planned activities are appropriate to the residents' needs and abilities. The activities are based on assessment and reflect the residents' social, cultural, spiritual, physical, cognitive needs/abilities, past hobbies, interests and enjoyments. Social and recreational assessment is completed within two weeks of admission in consultation with the family/whanau. The activities are conducted mostly separately in the rest home and two dementia wings and these are conducted by the healthcare assistants with oversight from an experienced qualified diversional therapist (DT). The DT in consultation with the FM and HCAs involved in activities develops a monthly planner which is posted on the notice boards and given to all residents. The activities are varied and appropriate for rest home level of care residents and residents living with dementia and are offered from Monday to Sunday.</p> <p>Diversional therapy twenty-four-hour care plans are in place and were sighted in all files sampled. Residents' files have a documented diversional therapy care plan that reflects their preferred activities of choice and are evaluated every six months or as necessary. The residents were observed to be participating in a variety of activities on the audit days. The planned activities and community connections are suitable for the residents. There are regular outings/drives, for all residents (as appropriate). Family members interviewed reported overall satisfaction with the level and variety of activities provided.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident care is documented on each shift by care staff in the progress notes. The registered nurses document weekly or as necessary. All noted changes by the health care assistants are reported to the RNs in a timely manner.</p> <p>Formal care plan evaluations, following reassessment to measure the degree of a resident's response in relation to desired outcomes and goals occur every six months or as residents' needs</p>

		<p>change. These are carried out by either the RNs in conjunction with family, GP and specialist service providers. Where progress is different from expected, the service is seen to respond by initiating changes to the service delivery plan.</p> <p>Problem/short term care plans are reviewed weekly or as indicated by the degree of risk noted during the assessment process. Interviews verified residents and family/whanau are included and informed of all changes.</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>	FA	<p>Residents and family/whanau are supported to access or seek referral to other health and/or disability service providers. If the need for other non-urgent services are indicated or requested, the GP, RNs or FM sends a referral to seek specialist service provider assistance from the district health board (DHB). Referrals are followed up on a regular basis by the registered nurses, FM or the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Acute or urgent referrals are attended to and the resident transferred to public hospital in an ambulance if required.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. Cleaning, laundry and kitchen staff have completed training in safe chemical handling. An external company is contracted to supply and manage all chemicals and cleaning products and they provide ongoing support and 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.</p> <p>There is provision and availability of protective clothing and equipment which staff were observed using.</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 11 October 2019) is publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. Efforts are made to ensure the environment is hazard free, that residents are safe and independence is promoted.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting.</p>

		Residents and staff confirmed they know the processes they should follow if any repairs or maintenance is required. They said that requests for repairs are appropriately actioned and that they are happy with the environment.
<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 more than adequate numbers of accessible bathroom and toilet facilities throughout the facility, including designated staff and visitor toilets. All are in good condition. One of the rest home bedrooms has a full ensuite bathroom, some have their own toilets and all have hand basins. The ablution areas in the secure dementia wings are conveniently located, and pictorially identified to be easily recognised. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote resident independence.</p> <p>Hot water temperature monitoring of all the hot water taps occurs monthly. The monitoring records sighted showed that temperatures are at or below 45 degrees centigrade.</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>All bedrooms are single occupancy. The rooms sighted were personalised with furnishings, photos and other personal items displayed. Bedroom doors in the secure areas are painted different colours and decorated in ways that assist the occupant to recognise their room.</p> <p>There is space to store mobility aids, wheel chairs and mobility scooters and more storage space is being created. Although some of the bedrooms are small, staff, residents and their families reported the bedrooms as adequate.</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>A second, separate lounge and dining area has been set up in secure dementia for a smaller group of less confused residents. This has significantly reduced the level of noise and incidents that were occurring during meal times when all 25 residents were dining together. These areas are also used for entertainment and activities and residents were observed happily engaging in these. The larger, main dining and lounge area is spacious and within easy walking distance to residents' rooms. Rest home residents have access to their own dining room and a smaller lounge for recreational activity but the nine residents interviewed said they were satisfied with what was provided. There are pleasant and interesting external areas for residents to access for privacy or quiet time, if required. Furniture is appropriate to the setting and residents' needs.</p>
Standard 1.4.6: Cleaning And	FA	Laundry is undertaken on site every day by a designated laundry person and the evening an night

<p>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>staff also carry out some cleaning and laundry duties. The laundry staff interviewed demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner.</p> <p>There is a small designated cleaning team who have attended training in safe chemical cleaning as confirmed by interview and review of training records. A cleaner is on site every day of the week. Chemicals and the cleaning trolley were stored in a lockable cupboard when not in use. Cleaning and laundry processes are monitored through the internal audit programme. There have been no issues or concerns about the provision of cleaning or laundry services since the previous audit.</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>	FA	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency. There is a fire evacuation plan approved by the New Zealand Fire Service. Trial evacuations take place every three months and records of the drill outcomes are sent to the New Zealand Fire Service. The most recent drill occurred on 28 August 2019. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>The onsite fire suppression systems are checked monthly by an appropriately qualified company.</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 36 residents and the Ministry of Civil Defence and Emergency Management recommendations for the region. The emergency lighting system was being regularly tested.</p> <p>The call bell system was functioning on audit day and residents and families reported staff respond promptly to call bells.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and a security company checks the premises at night. There have been no security incidents</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</p>	FA	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows and doors. Heating is provided by electricity in residents' rooms and in the communal areas. Areas were warm and well ventilated throughout the audit. Residents and families confirmed the facilities are maintained at a comfortable temperature.</p> <p>There is a designated smoking area for the two residents who smoke and the organisational smoke free workplace policy is known of and adhered to by staff.</p>

comfortable temperature.		
<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>Ohope Beach Care provides an environment that minimises the risk of infection to residents, staff and visitors by implementing an appropriate infection prevention and control programme. The clinical coordinator is the infection control coordinator (ICC) and is assisted by the facility manager (FM). They have access to external specialist advice from the GP and DHB infection control specialists when required. A documented role description for the ICC including role and responsibilities is in place.</p> <p>The infection control and prevention programme is 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 and prevention programme is appropriate for the size and complexity of the service.</p> <p>There are processes in place to isolate residents with infectious conditions when required. Hand sanitisers and gels are available for staff and visitors to use. There has been an infection outbreak since the last audit, and this was managed according to documented infection control and prevention guidelines and evidence was sighted. The service was shut down from the public for two weeks and relevant authorities were notified in a timely manner. 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 and FM are 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 management quality meetings and monthly staff meetings. Both have 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 and relevant legislative requirements and are readily available and are</p>	FA	<p>The organisation has documented policies and procedures in place that reflect current best practice. Staff were observed to be following the infection control policies and procedures. Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand washing technique and use of disposable aprons and gloves. Staff demonstrated knowledge on the requirements of standard precautions and able to locate policies and procedures.</p>

<p>implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>		
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>Staff education on infection prevention and control is conducted by the ICC, facility manager and other specialist consultants. The infection control coordinator and facility manager attended infection prevention and control training conducted by an external consultant to keep their knowledge current. A record of attendance is maintained and was sighted. The training education information pack is detailed and meets best practice and guidelines. External contact resources included the 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.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>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. Staff interviewed reported that they are informed of infection rates at monthly staff meetings and through compiled reports. 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.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Ohope Beach Care has a philosophy and practice of no restraint. There are policies and procedures in place which meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers if these are ever required.</p> <p>The FM who is the restraint coordinator provides regular education to staff on how to maintain a restraint free environment and demonstrated a sound understanding of the organisation's policies, procedures and practice and her role and responsibilities. Staff are also tested for their knowledge and understanding about restraint and enablers. Alternatives to restraint interventions being used are de-escalation, provision of a low stimulus environment, low beds, sensor mats, falls prevention program and increased staff vigilance.</p> <p>Interviews, documents reviewed, visual inspection and other observations, during the days of audit, confirmed there were no residents using restraint or enablers.</p>

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## Specific results for criterion where corrective actions are required

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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
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## Specific results for criterion where a continuous improvement has been recorded

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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.

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End of the report.