Ohope Beach Care Limited - Ohope Beach Care

Introduction

This report records the results of a Certification Audit of a provider of aged residential care services against the Ngā Paerewa Health and Disability Services Standard (NZS8134:2021).

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 0.4 of the Ngā Paerewa Health and Disability Services Standard (NZS8134:2021).

You can view a full copy of the standard 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: 3 October 2023 End date: 4 October 2023

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: 31

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 sections contained within the Ngā Paerewa Health and Disability Services Standard:

- ō tatou motika │ our rights
- hunga mahi me te hanganga │ workforce and structure
- ngā huarahi ki te oranga │ pathways to wellbeing
- te aro ki te tangata me te taiao haumaru │ person-centred and safe environment
- te kaupare pokenga me te kaitiakitanga patu huakita │ infection prevention and antimicrobial stewardship
- here taratahi │ restraint and seclusion.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the subsection in each of the sections. 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 subsections applicable to this service are fully attained with some subsections exceeded
	No short falls	Subsections applicable to this service are fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some subsections applicable to this service are partially attained and of low risk

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some subsections applicable to this service are 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 subsections applicable to this service are 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. There have been significant changes in staff since the previous surveillance audit in December 2021. This includes ongoing changes in the clinical nurse leader, and facility manager. On the days of audit, a registered nurse/acting facility manager and other administrator/leaders were overseeing day to day operations.

This certification audit was conducted against Ngā paerewa Health and disability services standard 2021 and the service provider's agreement with Te Whatu Ora, Health New Zealand Hauora A Toi Bay of Plenty.

The audit process included a pre audit review of the organisations policies and procedures, an onsite sample of residents' and staff files, observations and interviews with residents, whānau/family, the registered nurse/facility manager and team leaders, other key staff, the general practitioner (GP) and the director by telephone. Residents and family/whānau provided mixed feedback but said they felt safe care was provided.

There were 38 criteria identified that required improvements. Twelve of these were new or partially new to the sector when Ngā paerewa was introduced in 2022. The service provider did not have a transitional audit to Ngā paerewa. Other criteria rated as not being fully attained were; the complaints management system, effective communication, quality and risk, human resources, staff orientation, training, and performance management, entry to service, identification and documentation of residents early warning signs/deterioration, the timeliness of interRAI assessments and care plans, referral of residents, the activities program, reporting of

infection control issues to governance, and the identification and storage of hazardous chemicals/substances. These were reported to the owner, the health of older people portfolio manager for Te Whatu Ora and HealthCERT Manuatù Hauora Ministry of Health.

Ō tatou motika | Our rights

Includes 10 subsections that support an outcome where people receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of people's rights, facilitates informed choice, minimises harm, and upholds cultural and individual values and beliefs.		Some subsections applicable to this service are partially attained and of medium or high risk and/or unattained and of low risk.

There is a Māori health plan, and other related policies and documents to guide staff. This plus staff education ensures the needs of Māori residents are identified and met in a manner that respects their cultural values and beliefs. Training in Te Tiriti o Waitangi and the principles of mana motuhake had occurred and were practised. Cultural and spiritual needs are identified and considered in daily service delivery.

A Pacific plan and related policies and procedures guide staff in delivering Pacific models of care to residents who identify as Pasifika.

Residents and their whānau are informed of their rights according to the Code of Health and Disability Services Consumers' Rights (the Code) and these are upheld. Personal identity, independence, privacy and dignity are respected and supported. Residents are safe from abuse.

Residents and whānau receive information in an easy-to-understand format. Those interviewed said they were included when making decisions about care and treatment. Interpreter services are provided as needed. Whānau and legal representatives are involved in decision making that complies with the law. Advance directives are followed wherever possible.

The documented complaints policy aligns with consumer rights legislation and these standards.

Hunga mahi me te hanganga | Workforce and structure

Includes 5 subsections that support an outcome where people receive quality services through effective governance and a supported workforce.		Some subsections applicable to this service are partially attained and of medium or high risk and/or unattained and of low risk.

The organisation is governed by a private owner and service delivery is overseen by appointed leaders and clinical staff. The mission, values, scope and business goals of the organisation are documented.

There is a documented quality and risk management system which includes processes to meet these standards, the agreement with the funder, health and safety and other legislative and regulatory requirements. Incidents are being reliably reported and recorded in a timely way by all staff.

Enough staff are employed and rostered to be on site to meet the needs of residents 24 hours a day, seven days a week.

Management of health information meets these standards and the Health Records standard.

Ngā huarahi ki te oranga | Pathways to wellbeing

Includes 8 subsections that support an outcome where people participate in the development of their pathway to wellbeing, and receive timely assessment, followed by services that are planned, coordinated, and delivered in a manner that is tailored to their needs.		Some subsections applicable to this service are partially attained and of medium or high risk and/or unattained and of low risk.

Ohope Beach Care provided a holistic resident centred model of care. Information was provided to potential residents and family/whānau in a suitable format that ensured all decisions were based on informed consent.

Resident assessments informed care plan development. Care plans were implemented with input from the resident and family/whānau and contributed to achieving the resident's goals. A range of health and disability services were engaged to support the resident as required.

The activity programme acknowledged the resident's cultural heritage and included community activities.

The medicine management system was suitable for the service. Only staff who had been assessed as competent to administer medication were doing so.

The discharge and/or transfer of residents was safely managed. The general practitioner stated the care respected the resident's values and added quality to their life.

Te aro ki te tangata me te taiao haumaru | Person-centred and safe environment

Includes 2 subsections that support an outcome where Health and disability services are provided in a safe environment appropriate to the age and needs of the people receiving services that facilitates independence and meets the needs of people with disabilities.		Subsections applicable to this service are fully attained.

The facility meets the needs of residents and was clean and well maintained. There is a current building warrant of fitness. Electrical equipment has been tested as required. External areas are accessible, safe and provide shade and seating, and meet the needs of people with disabilities.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Staff, residents and whānau understood emergency and security arrangements. Residents reported a timely staff response to call bells. Security is maintained.

Te kaupare pokenga me te kaitiakitanga patu huakita | Infection prevention and antimicrobial stewardship

Includes 5 subsections that support an outcome where Health and disability service providers' infection prevention (IP) and antimicrobial stewardship (AMS) strategies define a clear vision and purpose, with quality of care, welfare, and safety at the centre. The IP and AMS programmes are up to date and informed by evidence and are an expression of a strategy that seeks to maximise quality of care and minimise infection risk and adverse effects from antibiotic use, such as antimicrobial resistance.		Some subsections applicable to this service are partially attained and of medium or high risk and/or unattained and of low risk.

The organisation supported the safety of residents and staff via the infection prevention and antimicrobial stewardship programmes. The programmes were appropriate for the size, complexity, and scope of service. The infection prevention coordinator was

responsible for the implementation the programme. The infectious diseases/pandemic plan had been tested. Staff were educated in the principles of infection control. A surveillance programme was implemented that captured data relating to the type of infection.

Here taratahi | Restraint and seclusion

Includes 4 subsections that support outcomes where Services shall aim for a restraint and seclusion free environment, in which people's dignity and mana are maintained.		Subsections applicable to this service are fully attained.

The service has a philosophy and practice of no restraint. This is supported by the director and policies and procedures. There were no residents using restraints at the time of audit. Staff demonstrated knowledge and understanding of providing the least restrictive practice, de-escalation techniques and alternative interventions.

Summary of attainment

The following table summarises the number of subsections 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)
Subsection	0	16	0	2	4	5	0
Criteria	0	129	0	14	20	4	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)
Subsection	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Ngā Paerewa Health and Disability Services Standard

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

There may be subsections in this audit report with an attainment rating of 'not applicable' which relate to new requirements in Ngā Paerewa that the provider is working towards. The provider will be expected to meet these requirements at their next audit.

For more information on the standard, please click here.

For more information on the different types of audits and what they cover please click here.

Subsection with desired outcome	Attainment Rating	Audit Evidence
Subsection 1.1: Pae ora healthy futures Te Tiriti: Māori flourish and thrive in an environment that enables good health and wellbeing. As service providers: We work collaboratively to embrace, support, and encourage a Māori worldview of health and provide high-quality, equitable, and effective services for Māori framed by Te Tiriti o Waitangi.	FA	The organisation has embedded a Māori model of health into their care planning process. The principles of Te Tiriti o Waitangi are actively acknowledged when providing support to Māori residents who make up slightly more than a quarter of the resident population. Partnership, protection, and participation was evident and confirmed in interview with residents who identified as Māori. The organisation's Māori Health Plan reflected a commitment to Te Tiriti o Waitangi and providing inclusive person/ whānau centred support. Around 25% of the workforce identifies as Māori staff. Interviews with these staff confirmed knowledge and understanding about local Iwi and Māori organisations. The service has recently appointed a kaumātua. Staff who identified as Māori, confirmed that services were provided in a culturally safe manner. The Māori residents and their whānau reported that their mana is protected and that they are treated with dignity and respect and that they are not afraid to speak up if they feel their world view has not been fully considered.

Subsection 1.2: Ola manuia of Pacific peoples in Aotearoa The people: Pacific peoples in Aotearoa are entitled to live and enjoy good health and wellbeing. Te Tiriti: Pacific peoples acknowledge the mana whenua of Aotearoa as tuakana and commit to supporting them to achieve tino rangatiratanga. As service providers: We provide comprehensive and equitable health and disability services underpinned by Pacific worldviews and developed in collaboration with Pacific peoples for improved health outcomes.	FA	The Pacific plan which aligns with national strategies was developed with input from Pacific communities and supports culturally safe practices for Pacific peoples using the service. Although there were no Pasifika residents, a staff member said Pasifika residents would have their cultural, spiritual needs and beliefs identified, recorded, and considered. One staff member who identified as Pasifika confirmed knowledge of local Pacific communities and organisations who are available to advise and provide information. The service has detailed policies on a range of Pasifika cultures which can also guide staff.
Subsection 1.3: My rights during service delivery The People: My rights have meaningful effect through the actions and behaviours of others. Te Tiriti:Service providers recognise Māori mana motuhake (self-determination). As service providers: We provide services and support to people in a way that upholds their rights and complies with legal requirements.	FA	The policy reflected the Code of Health and Disability Services Consumers' Rights (the Code). Observation during the audit confirmed that staff implemented the Code in their daily practice. The Code was displayed in communal areas in English and te reo Māori. Residents/whānau confirmed that upon admission a pack was provided that included information about the Code and the national advocacy service. National advocacy brochures were sighted and available at the entrance of the facility. Staff stated they had completed training relating to consumer rights, advocacy and cultural awareness (refer to 2.3.3). Clinical records held evidence that Māori mana motuhake was respected, and this was confirmed by residents and family/ whānau.
Subsection 1.4: I am treated with respect The People: I can be who I am when I am treated with dignity and respect. Te Tiriti: Service providers commit to Māori mana motuhake.	FA	A social/cultural profile was documented in residents' files sampled, which included information such as the resident's religious beliefs, relationships, abilities, and disabilities. Staff described ways in which they respected residents' dignity, privacy, and confidentiality.

As service providers: We provide services and support to people in a way that is inclusive and respects their identity and their experiences.		Observation of staff interactions with residents, verified that they were treated and addressed in a manner which acknowledged and respected their identity and mana. Staff confirmed they had completed Te Tiriti o Waitangi training, and this was verified by education attendance records (refer to 2.3.3). Staff provided examples of how they acknowledged Māori traditional values for example, the placement of food, and the placement of soiled linen and clothing (noa and tapu). Signage throughout the facility was written in English and te reo Māori. Residents were enabled to participate in te ao Māori by the inclusion of traditional Māori foods, singing waiata in te reo Māori, and attending community events with whānau. Residents and whānau confirmed the cultural aspects of their wairua were met and there was sufficient opportunity to participate in te ao Māori.
Subsection 1.5: I am protected from abuse The People: I feel safe and protected from abuse. Te Tiriti: Service providers provide culturally and clinically safe services for Māori, so they feel safe and are protected from abuse. As service providers: We ensure the people using our services are safe and protected from abuse.	FA	There was a policy that directed behaviour and actions to ensure residents were not exposed to discrimination, abuse, neglect, or harassment. Staff discussed signs of bullying, intimidation, abuse, and neglect, and advised what action they would take if they identified the signs. They also discussed professional boundaries and their role in maintaining these. Staff had knowledge pertaining to institutional racism and discussed options available to ensure it did not occur within the service. Resident's personal possessions were identified and observed to be respected. The admission agreement documented the responsibilities of the resident and the service regarding personal property and finances. Documentation was sighted that confirmed the flow of the resident's comfort funds was managed appropriately. Care-plans documented a strengths-based and holistic model of care was implemented that contributed to the wellbeing of all residents. Residents and whānau confirmed that staff maintained professional boundaries, and that residents were not abused. They also stated that they had not witnessed racism within the service.

Subsection 1.6: Effective communication occurs The people: I feel listened to and that what I say is valued, and I feel that all information exchanged contributes to enhancing my wellbeing. Te Tiriti: Services are easy to access and navigate and give clear and relevant health messages to Māori. As service providers: We listen and respect the voices of the people who use our services and effectively communicate with them about their choices.	PA Low	Written information was provided to residents and family/whānau as required. Verbal information was provided and repeated as required by staff to ensure the resident/s and family/whānau understood. Opportunities for questions were provided. Clinical records confirmed that the service communicated with other service providers as appropriate for example the general practitioner (GP) and the Mental Health of Older Persons Service (MHOPS). Documentation in records verified that open communication was practiced, and this was confirmed by residents and family/whānau. Interpreter services were available should they be required. There was opportunity for improvement related to resident meetings.
Subsection 1.7: I am informed and able to make choices The people: I know I will be asked for my views. My choices will be respected when making decisions about my wellbeing. If my choices cannot be upheld, I will be provided with information that supports me to understand why. Te Tiriti: High-quality services are provided that are easy to access and navigate. Providers give clear and relevant messages so that individuals and whānau can effectively manage their own health, keep well, and live well. As service providers: We provide people using our services or their legal representatives with the information necessary to make informed decisions in accordance with their rights and their ability to exercise independence, choice, and control.	FA	The informed consent processes align with the Code. Residents and family/whānau confirmed they were provided suitable information to enable informed consent for all aspects of their care. Clinical records included signed consent for photographs, collection and storage of health information, and outings. At the time of the audit there were no residents who had completed an advance directive, however staff and the GP stated that these would be followed if available. Clinical files verified that the resident's resuscitation status was documented and signed by the GP. Competent residents had also signed the form, or the (Enduring Power of Attorney) EPoA/court appointed guardian if the resident had been deemed not competent. Staff discussed tikanga guidelines and advised this had been a component of their Te Tiriti o Waitangi training. They advised who they would approach for further information should it be required. Māori residents and whānau confirmed that the provision of care was provided in a manner that reflected best practice tikanga guidelines.

Subsection 1.8: I have the right to complain The people: I feel it is easy to make a complaint. When I complain I am taken seriously and receive a timely response. Te Tiriti: Māori and whānau are at the centre of the health and disability system, as active partners in improving the system and their care and support. As service providers: We have a fair, transparent, and equitable system in place to easily receive and resolve or escalate complaints in a manner that leads to quality improvement.	PA Moderate	The process and policies meet the requirements of the Code of Health and Disability Services Consumer Rights (The Code) however there was insufficient evidence that staff had been adhering to these. The only complaints available for auditing were written on incident/accident forms and were not being formally acknowledged in writing. There was no complaints register, and a new complaint form (korero mai/feedback) had been introduced without an explanation to staff or residents about its use. The form did not provide any guidance or information about the complaints process. An improvement is required in criteria 1.8.3 and 1.8.4. Staff made changes to the complaint forms on the days of audit to facilitate an improvement. Māori residents and whānau said they understood their right to make a complaint and that they had no hesitation in raising concerns. One family member commented they had called the owner directly to complain. There was no documented evidence of this, however the owner confirmed this had happened. There have been no known complaint investigations from any external agencies including the funder of services, or the office of the Health and Disability Commission (HDC) since the previous audit.
Subsection 2.1: Governance The people: I trust the people governing the service to have the knowledge, integrity, and ability to empower the communities they serve. Te Tiriti: Honouring Te Tiriti, Māori participate in governance in partnership, experiencing meaningful inclusion on all governance bodies and having substantive input into organisational operational policies. As service providers: Our governance body is accountable for delivering a highquality service that is responsive, inclusive, and sensitive to the cultural diversity of communities we serve.	PA High	Ohope Beach Care has been owned and operated privately for 13 years. The owner/director interviewed by telephone said they understood their obligation to comply with current legislation, contractual and regulatory requirements but was not fully conversant with all the new requirements under Ngà Paerewa. A new facility manager was appointed in early 2022. The facility manager had been on leave since 18 September 2023 and an RN who commenced work in a casual capacity on 02 September was appointed initially as a temporary clinical leader (whilst the clinical nurse was on leave) and then as the acting manager, in collaboration with other senior staff. This person does not have proven experience in managing an aged care facility. An improvement is required in 2.1.3. The 2023 business plan contained the scope of services, organisational vision/direction and a mission statement. Goals were

		documented with time frames however these did not have clear objectives or an action plan. There was no evidence found that the goals were being reviewed for progress. An improvement is required in criterion 2.1.2. An administrator stated they had been compiling monthly reports for the director that contained information about occupancy, service delivery issues and highlights, staffing information, maintenance, complaints and compliments, adverse events, and internal audit outcomes, however according to the director only one of these had been received. The owner/director of Ohope Beach Care demonstrated commitment to quality and risk management by purchasing an age care specific system over 10 years ago which continues to be updated to meet changes in the sector by the external owner of the system. This was being used effectively at the last audit. Deviations from the system and non-adherence to the documented policies and procedures has subsequently compromised the integrity of the system. Improvements required in relation to this are reported in subsection 2.2 Quality and Risk. The owner/director who is a sole trader, said they had not undertaken any training in Te Tiriti o Waitangi, health equity or cultural safety. The director was not familiar with all the governance obligations under Ngā paerewa. Specifically, the new requirements related to equity and improved outcomes for Māori and tangata whaikaha/ people with disabilities, ensuring there were no barriers to the service and having substantive Māori representative input into organisational procedures. A member of staff said they had made some preliminary arrangements for kaumātua and kuia services, but these had not been fully implemented. The pre audit document review revealed an intention to establish te roopu/Māori staff group, but only one of the staff spoken to had knowledge of this. Improvements are required in criteria 2.1.5, 2.1.6, 2.1.7, 2.1.9 and 2.1.10. Residents and whānau participate in the planning, implementation, monitoring, and evaluation of service delivery. Some evidence of monitoring, and evaluation of service delivery was seen in completed satisfaction surveys from three residents dated April 2023. These did not indicate any concerns. The information technology (IT) manager

		undertook to conduct another wider satisfaction survey within the next six months. The facility has a maximum capacity for up to 36 residents, comprising 11 rest home and 25 dementia beds (this number of beds was previously approved by the funder). On the days of audit 31 beds were occupied by 10 rest home level care residents and 21 residents in the secure unit. One of the residents in the secure unit was being funded by the Accident Compensation Corporation (ACC) including an additional 16 hours of support per day. This person's diagnosis and ongoing aggressive behaviour indicated they had not been suitably placed. An improvement is required in 3.1.2. Services are provided under the Age Related Residential Care (ARRC) agreement with Te Whatu Ora, Health New Zealand Hauora a Toi Bay of Plenty. The service also holds an agreement for respite/short stay care. A moderate percentage of residents were not subsidised and paying privately for their care. There was no clear clinical governance structure. This could have been incorporated into meetings of the quality improvement committee, but the committee had been in abeyance for some time. An improvement is required in criterion 1.2.11. This is also linked to quality and risk 2.2.3.
Subsection 2.2: Quality and risk The people: I trust there are systems in place that keep me safe, are responsive, and are focused on improving my experience and outcomes of care. Te Tiriti: Service providers allocate appropriate resources to specifically address continuous quality improvement with a focus on achieving Māori health equity. As service providers: We have effective and organisation-wide governance systems in place relating to continuous quality improvement that take a risk-based approach, and these systems meet the needs of people using the services and our health care and support workers.	PA High	Ohope Beach Care had a clearly described quality and risk management system which is kept current by the external owner of the system. This system has not been fully adhered to for 18 months. For example, the system template for documenting the quality and risk management plan and goals had not been completed. There were no documented quality goals or other means of monitoring progress toward achieving quality outcomes. Internal audits, resident/relative satisfaction surveys and staff surveys had not been reliably occurring. Improvements are required in 2.2.2 and 2.2.3 Similarly, policies and procedures that describe all potential internal and external risks and corresponding mitigation strategies were not being followed. New methods introduced did not identify or monitor

		all service risks and did not mitigate clinical risks reported through the incident reporting system. Improvements are required in criteria 2.2.4 and 2.2.5. There were no perceptible barriers to entry for Māori and their individual needs were being identified and catered for in equitable and respectful ways. The service monitors the ethnicity of clients in and out of the service and facilitates residents access to other health services and resources when required. Māori residents said their cultural values and rights to practice tikanga Māori were upheld and respected and they had no concerns about staff being able to deliver quality health care for Māori. Staff attended training related to Te Tiriti, the use of te whare tapa wha Māori model of care, enabling Māori mana motuhake and achieving health equity in July 2023. Details about the content of the education were not recorded and staff expressed mixed views about the quality and usefulness of the training. Initiatives aimed at improving the health status of Māori residents and measuring improvements in equity are yet to be implemented. An improvement in criteria 2.2.8 is required. Essential notification reporting has been occurring, although the newly established section 31 register has not been kept updated. Section 31 notifications had been submitted for absconding residents, medication errors, management changes and the sudden death of a visitor on site since the previous audit. The health of older people portfolio manager confirmed that Te Whatu Ora were notified of positive COVID-19 cases in 2022. Staff did not know of any other significant events, coroner's enquiries or police investigations occurring since the previous audit.
Subsection 2.3: Service management The people: Skilled, caring health care and support workers listen to me, provide personalised care, and treat me as a whole person. Te Tiriti: The delivery of high-quality health care that is culturally responsive to the needs and aspirations of Māori is achieved through the use of health equity and quality improvement tools.	PA High	There is a documented and implemented process for determining staffing levels and skill mixes to provide culturally and clinically safe care, 24 hours a day, seven days a week (24/7). A service leader estimated that 25 percent of the workforce identify as Māori and/or Pasifika. Care staff reported that at the time of audit, there were enough staff

As service providers: We ensure our day-to-day operation is managed to deliver effective person-centred and whānau-centred services.		to complete the work allocated to them, although there had been difficulty rostering enough skilled and experienced staff. Residents and whānau interviewed supported this. A part time employed RN with current interRAI competencies works 25 hours per week Monday to Friday and the acting RN facility manager has been working 12-hour days and covering after hour's calls. Four care staff were being rostered for each morning shift seven days a week in the secure unit which includes a health care assistant (HCA) providing 16 hours per day for the ACC resident. Staff expressed concerns about their ability to sustain this. There were not enough care staff who were considered competent to administer medicines on each shift. An improvement is required in criterion 2.3.1. One HCA is rostered in the rest home for 10 rest home residents on each shift over a 24-hour period. Three HCAs are rostered to work in the secure unit for afternoon shift and two on night duty. Most care staff, the RNs and activities staff have current first aid certificates. Allied staff such as the diversional therapist, two activities assistants, two cooks and two kitchen assistants are allocated sufficient hours to meet residents' needs and provide smooth service delivery. Dedicated staff carry out laundry and housekeeping duties seven days a week. There are additional administrative staff, and an IT manager employed for variable hours each week. The new system for holding staff information was not being reliably used and could not confirm staff experience, qualifications or competencies. An improvement is required in criterion 2.3.2. Continuing education for staff had not been clearly planned. The annual staff education plan was not being followed and there was no cohesive or integrated system for recording individual training. An improvement is required in 2.3.3. A staff training day in July 2023 included education on infection control, restraint minimisation, residents' rights, Te Tiriti o Waitangi and Māori models of care. The training also included aspects of cultural safety, and health equity but there was no record of the content covered in these sessions. There were no readily accessible methods for determining which 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 funder. Evidence needed to be collected by calling each staff member to obtain verbal confirmation. An improvement is required in criterion 2.3.4. Rudimentary evidence gathered showed that 16 of the 23-care staff employed had achieved qualifications on the New Zealand, Qualifications (NZQA) framework. Eleven were at level four, three were at level three and one was at level two, and one had completed level one. It was not clear that all staff working in the dementia unit had commenced or completed the limited career path (LCP) modules for dementia. One RN is accredited and maintaining competencies to conduct interRAI assessments. There was no evidence that staff had been informed or trained in how to support and maximise residents and whānau participation in the service. An improvement is required in criterion 2.3.5 which links to the finding in criterion 1.6.4. There was no evidence of methods or systems for identifying, collecting and sharing evidence based and current Māori health information. An improvement is required in 2.3.6. More training and development of staff knowledge and understanding about health equity needs to occur. An improvement is required in criterion 2.3.7. Staff did not report feeling well supported and safe in the workplace. An improvement is required in criterion 2.3.8
Subsection 2.4: Health care and support workers The people: People providing my support have knowledge, skills, values, and attitudes that align with my needs. A diverse mix of people in adequate numbers meet my needs. Te Tiriti: Service providers actively recruit and retain a Māori health workforce and invest in building and maintaining their capacity and capability to deliver health care that meets the needs of Māori. As service providers: We have sufficient health care and support workers who are skilled and qualified to provide clinically and culturally safe, respectful, quality care and services.	PA High	Staff management policies are based on good employment practice and relevant legislation but there was insufficient information held in the electronic employment records system to confirm that procedures were being implemented as required. An improvement is required in criterion 2.4.1. Not all staff records sampled had job descriptions and one staff member stated they had not their role clarified. An improvement is required in 2.4.2 Regulated staff said their qualifications including current membership with professional bodies and annual practicing certificates (APC) had been confirmed prior to employment, but

		there was no evidence that the currency of APCs was being monitored. Both RNs produced evidence of current APCs during the audit. Evidence of other health practitioners practicing certificates, such as the dispensing pharmacist, and general practitioner was not found. The exact number of staff employed in full time, part time or casual roles was not clear initially and took some time to determine. An improvement is required in 2.4.3. There was limited evidence that all new staff had completed orientation tailored for their specific role. An improvement is required in 2.4.4. There was no evidence that annual formal performance appraisals were completed or that 90-day post-employment reviews occurred. An improvement is required in 2.4.5 The service provider had not determined the cultural make-up of their workforce and could only estimate the percentage of Māori and Pasifika health care and support workers. There is a diverse mix of staff employed but individual staff ethnicity data had not been recorded in accordance with Health Information Standards Organisation. An improvement is required in 2.4.6 Staff satisfaction was not being routinely surveyed and many staff have resigned since the previous audit, citing dissatisfaction according to interviews with internal and external stakeholders. Informal and collegial support was in evidence.
Subsection 2.5: Information The people: Service providers manage my information sensitively and in accordance with my wishes. Te Tiriti: Service providers collect, store, and use quality ethnicity data in order to achieve Māori health equity. As service provider: We ensure the collection, storage, and use of personal and health information of people using our services is accurate, sufficient, secure, accessible, and confidential.	FA	The residents' files are paper based, and all staff make entries in the progress notes. The RN completes care plans electronically, and copies are printed and put in the residents' paper file. These documents were sighted in the residents' clinical records sampled. All necessary demographic, personal, clinical and health information was in the records but not all had been entered in a timely way. This is linked to a finding in criterion 3.1.1. Clinical notes were current and integrated with GP and allied health service provider notes. This included interRAI assessment information entered into the electronic database and reports printed and stored in the residents' files. The resident care records were legible with the name and designation of the person making the entry identifiable. The

		electronic medication management system in use records prescriptions and administration times. Archived records are held securely on site and are readily retrievable. Administrative staff and service leaders are responsible for archiving clinical records. Residents' information is held for the required period before being destroyed. No personal or private resident information was on public display during the audit. The residents' files were kept in locked nurses' station. A shredder is used for destruction of unwanted confidential information. Staff have individual passwords to access policies, forms, and any electronic records. This service provider is not responsible for National Health Index registration of people receiving services.
Subsection 3.1: Entry and declining entry The people: Service providers clearly communicate access, timeframes, and costs of accessing services, so that I can choose the most appropriate service provider to meet my needs. Te Tiriti: Service providers work proactively to eliminate inequities between Māori and non-Māori by ensuring fair access to quality care. As service providers: When people enter our service, we adopt a person-centred and whānau-centred approach to their care. We focus on their needs and goals and encourage input from whānau. Where we are unable to meet these needs, adequate information about the reasons for this decision is documented and communicated to the person and whānau.	PA Moderate	Information about Ohope Beach Care was available from the service in printed format, and further information was available on the website. Most enquiries were via the phone or a personal visit, and the administrator and/or the facility manager provided the required information and answered questions. Entry to the service was usually a family/whānau initiated process. The clinical records of the sampled dementia residents confirmed that a mental health of older person's psychiatrist had assessed the resident prior to admission. Documentation confirmed that the residents enduring power of attorney (EPoA), had consented to the resident's admission. Entry and decline records sighted confirmed that persons eligible for the service were not declined admission. The records included the person's ethnicity. Relationships with Māori organisations were in place, and residents and family/whānau expressed satisfaction with the admission process and the delivery of care. They confirmed they were treated with dignity and respect. There was a documented entry policy that reflected current entry

		and decline requirements; however, this was not always implemented.
Subsection 3.2: My pathway to wellbeing The people: I work together with my service providers so they know what matters to me, and we can decide what best supports my wellbeing. Te Tiriti: Service providers work in partnership with Māori and whānau, and support their aspirations, mana motuhake, and whānau rangatiratanga. As service providers: We work in partnership with people and whānau to support wellbeing.	PA High	Residents received individualised support that met the physical, cultural, spiritual, and social dimensions of their wellbeing. A registered nurse was responsible for completing assessments and developing care-plans. Clinical records demonstrated that resident assessments were holistic and included for example skin integrity, pain, lived experience, cultural, and spiritual requirements. Falls risk, continence, and mobility, were assessed. Care-plans contained interventions to manage the individual resident's assessment/s and interRAI clinical assessment protocols (CAPS). Progress notes, and observation, confirmed that the documented interventions had been implemented. Family/whānau confirmed they were involved in the assessment and care-planning of resident needs. Clinical files of residents in the dementia wing included behaviour management plans. Potential behavioural triggers and interventions were documented. Staff described how the triggers were avoided or minimised. They also discussed interventions suitable to de-escalate a resident's challenging behaviour. Short-term care-plans were documented in response to a resident developing an acute health condition for example an infection or area of impaired skin integrity. These were updated as required and signed off when the condition had resolved. Medical services were provided by a GP service and supported by a nurse practitioner (NP). The clinical record and medication files confirmed that residents were seen and assessed by the GP/NP every three months. If a resident's condition changed between three monthly reviews the GP/NP was notified and reviewed the resident. Evidence of this was sighted in the clinical record, and verbally by the GP. Residents were supported to identify their own pae ora outcomes, with family/whānau involvement. Care-plans for Māori residents

		reflected cultural values and te whare tapa wha model of care. Māori residents and whānau interviewed stated that care was provided in a manner that respected their mana, and that access to support persons was encouraged. Policies, procedures, and interviews with staff confirmed that the service understood Māori oranga and customs. Visiting hours were flexible to allow family/ whānau to visit and support the resident. Staff provided information to residents and their family/whānau as required. Resident's and their family/whānau confirmed general satisfaction with the provision of care at the service. The GP confirmed that care was provided in a manner that was respectful and that regular contact was made to monitor the resident's well-being. Residents had a nursing assessment completed on admission and a short-term care plan developed, however the initial interRAI assessment and long-term care plans were not consistently completed within the required timeframes. An opportunity to improve the identification, documentation and escalation of early warning signs of a resident's decline was observed. Although changes in the level of care some residents required were documented, relevant assessments and referrals to enable the change had not been made.
Subsection 3.3: Individualised activities The people: I participate in what matters to me in a way that I like. Te Tiriti: Service providers support Māori community initiatives and activities that promote whanaungatanga. As service providers: We support the people using our services to maintain and develop their interests and participate in meaningful community and social activities, planned and unplanned, which are suitable for their age and stage and are satisfying to them.	PA Moderate	The programme was planned and delivered by one diversional therapist (DT) and two assistants. One programme was developed and was on display through out the service. Activities took place in both the dementia unit and the rest-home. These activities were not run simultaneously, and staff encouraged rest-home residents to attend activities in the dementia unit as suitable/available. Residents deemed suitable in the dementia unit were supported to join the activities in the rest-home. Outings occurred weekly for drives in the countryside, picnics and

		suitable community activities. Recently ten residents had attended a school production. Family/whānau also took residents into the community to attend celebrations and events. Clinical files sampled confirmed that assessments of the resident's life skills, experiences, cultural and social profiles were considered in the development of the activities care-plan. Residents, family/ whānau confirmed they had been engaged in the assessment and planning of the activities care plan. Care-plans of residents in the dementia unit documented activities that were suitable for the resident 24 hours of the day and acknowledged the resident's life experiences. Health care assistants were responsible for initiating and supervising activities for these residents when an activities staff member was not available. Examples of activities included watching television, going for walks, tending to the service animals (chooks), doing cross words, and looking at magazines. The service had recently made a connection with a local Māori group and a kaumātua to begin providing support to ensure the service provided Māori with opportunities to participate in te ao Māori and enhance the health needs of Māori. Although the programme included activities that promoted physical, social, cultural and intellectual skills, the programme was not available at sufficient times or places to consistently meet the needs of the residents.
Subsection 3.4: My medication The people: I receive my medication and blood products in a safe and timely manner. Te Tiriti: Service providers shall support and advocate for Māori to access appropriate medication and blood products. As service providers: We ensure people receive their medication and blood products in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	The medication management system reflected current recommended best practice. An electronic programme was used for the prescribing and recording of the administration of medication. Medications were dispensed by the pharmacy using a pre-packaged system. A staff member collected medication/s from pharmacy and delivered discontinued/expired medications to the pharmacy. Two medication competent staff members checked the medications prior to them being placed in the medication cupboard. Medication administration was performed by medication competent health care assistants. A medication round was observed, and staff

		demonstrated competency administrating medication. Eye drops, ointments and creams had a documented opening date. During the audit no medications were observed to be out of date. There were two medication cupboards, one for the dementia unit, and one for the rest-home. Both were locked and inaccessible to unauthorised persons. Controlled medications were stored appropriately in one area only. Documentation of these reflected legislative requirements. The medication cupboards and the one medication fridge was temperature monitored as per policy. All medication prescriptions were completed as per regulations, including the documentation of allergies and sensitivities. The GP/NP had reviewed the medication chart every three months or more frequently as required. Over the counter medications (OTC) were discussed with the resident and family/whānau by the GP/NP. Where appropriate these were prescribed and were administered by staff. This was confirmed by observation and by resident and family/whānau. Standing orders or self-administration of medication does not occur in this service. Residents, including Māori residents and their whānau, were supported to understand their medications, and this was confirmed by residents and whānau. Medication incidents were documented (refer to 2.2.5). The GP stated that the medication system implemented was appropriate for the service.
Subsection 3.5: Nutrition to support wellbeing The people: Service providers meet my nutritional needs and consider my food preferences. Te Tiriti: Menu development respects and supports cultural beliefs, values, and protocols around food and access to traditional foods. As service providers: We ensure people's nutrition and hydration	FA	All aspects of food management complied with current legislation and guidelines. There was a current food control plan that expires September 2024. The menu reflected the Ministry of Health nutritional guidelines for the older person and had been approved by a registered dietician in 2021, arrangements were being made for re-review at the time of the audit. Prepared food was covered, dated and stored in the fridge. Cleaning

needs are met to promote and maintain their health and wellbeing.		records of the kitchen and its appliances were completed daily. Fridge and freezer temperature records were maintained, and records verified these were within acceptable parameters. Each resident had a nutritional assessment completed by a registered nurse on admission. Individual dietary requirements were documented in the resident's clinical file, and a copy of this information was sighted in the kitchen. Resident's diets are modified as required, and kitchen staff confirmed awareness of the dietary needs, allergies/ sensitivities, likes and dislikes of residents. Residents assisted with making toast and setting and clearing of the tables as able. There were two dining rooms, one in the rest-home and one in the dementia unit. Meals were served in the dining room, but if requested/required were able to be served in the resident's room. Observation of meals confirmed that sufficient time was provided to eat and enjoy the dining experience. Assistance was provided to residents as necessary. The kitchen manager discussed how the menu, food preparation, cooking and serving is undertaken with consideration of cultural values and beliefs, including Māori. At times of celebration, for example during Matariki, resident birthdays, and ANZAC day special food is prepared that reflects the nature of the day, and the resident's cultural origins. The service has prepared and served hangi and also a smoked fish dish prepared and cooked in a traditional Māori way. Family and whānau at times bring food with cultural significance to a resident/s, and residents go out with whānau for meals/kai and celebrations. Staff have access to the kitchen 24 hours per day and are able to prepare hot drinks and serve snacks to residents as desired. Residents and whānau interviewed confirmed satisfaction with the food service.
Subsection 3.6: Transition, transfer, and discharge	FA	The transfer and discharge policy provided instruction to safely manage the transfer and discharge of residents. Registered nurses

The people: I work together with my service provider so they know what matters to me, and we can decide what best supports my wellbeing when I leave the service. Te Tiriti: Service providers advocate for Māori to ensure they and whānau receive the necessary support during their transition, transfer, and discharge. As service providers: We ensure the people using our service experience consistency and continuity when leaving our services. We work alongside each person and whānau to provide and coordinate a supported transition of care or support.		stated they were aware of the policy and knew how to access it. They stated they were responsible for arranging the transfer or discharge of a resident. Acute transfers to the public hospital occurred when there was a sudden change in a resident's health status and the senior health care assistant, and registered nurse in conjunction with the GP determined the resident required specialised care. The national 'yellow envelope' system was used. In the envelope was included a copy of the required documents as identified on the envelope. The family/whānau were notified of the residents need to transfer to the hospital. Confirmation of the process was sighted in clinical records. Discharge was planned and facilitated with the resident and family/whānau involvement when a resident's health status had changed. A registered nurse or/and senior HCA also known as the registered nurse assistant liaised with the GP/NP to ensure the provision of care remained appropriate until the day the resident discharged. Family/whānau were kept informed of the resident's health status. Upon discharge relevant information was made available to the new service provider. Patients and family//whānau confirmed they were aware of and provided information about other health and disability services when indicated or requested.
Subsection 4.1: The facility The people: I feel the environment is designed in a way that is safe and is sensitive to my needs. I am able to enter, exit, and move around the environment freely and safely. Te Tiriti: The environment and setting are designed to be Māori-centred and culturally safe for Māori and whānau. As service providers: Our physical environment is safe, well maintained, tidy, and comfortable and accessible, and the people we deliver services to can move independently and freely throughout. The physical environment optimises people's sense of belonging, independence, interaction, and function.	FA	The building had a current warrant of fitness with an expiry date of 11 October 2023. There have been no changes to the building structure or footprint since the previous audit. Systems were in place to ensure the residents' physical environment and facilities were fit for their purpose and maintained. Inspection of the internal and external environments revealed no concerns. Residents were observed to be independently accessing the gardens, decks, and external areas. There was enough safe and suitable seating, handrails and flat walking surfaces and shade options provided. The building and grounds are in reasonable repair. Plant and

		equipment is being well maintained and new equipment to promote independence and mobility is acquired as needed. Records and receipts sighted confirmed at least annual checking, tagging and testing, and calibration of electrical devices and medical equipment. For example, testing and tagging of all plug in electrical equipment on 28 July 2023 and safety checks of electrical beds, sit on scales, and calibration of thermometers and blood pressure monitors has been occurring by the manufacturer or supply company. Improvements have been made and the internal environment is inclusive of residents' cultures. For example, signage throughout the home is in te reo Māori and English, and the internal décor reflects all cultures. A sufficient number of conveniently located and disability accessible bathrooms and toilets for residents and staff are available. These are clearly identified, designated as male and female and have functional privacy locks. Hot water temperature monitoring was occurring, as confirmed by the records sighted. Internal audits of equipment and the environment were being carried out regularly and remedial or preventative maintenance occurs in a timely manner. There were no shared bedrooms on the days of audit. Each resident's bedroom was light filled, warm and well-ventilated by large opening windows and individual heaters. Because the scope of the service is rest home only, there is seldom a need for hoists or lifting equipment. One resident in the dementia unit needed mobility and lifting equipment and a staff member commented that their bedroom was not large enough to easily accommodate this or to manoeuvre. There were no larger rooms in the unit and the ongoing placement of this resident was under consideration, therefore a finding was not issued. There was a wash basin in all bedrooms, and these were furnished and decorated according to the occupant's preferences. Communal dining and recreational areas were spacious and easy to access with dual setting heat and air-conditioning heat pumps. Hallways and bathrooms were heated by wall heaters. There have been no new buildings. Interviews confirmed the service provider understands the requirements to consult and co-design any proposed new environments to ensure they reflect the aspirations of

		Māori.
Subsection 4.2: Security of people and workforce The people: I trust that if there is an emergency, my service provider will ensure I am safe. Te Tiriti: Service providers provide quality information on emergency and security arrangements to Māori and whānau. As service providers: We deliver care and support in a planned and safe way, including during an emergency or unexpected event.	FA	Emergency, natural disaster and civil defence plans and policies direct the service in their preparation for disasters and described the procedures to be followed. Staff have been trained and knew what to do in an emergency. There is always at least one staff member with a current first aid certificate on site. The RN is available on call after hours and staff had also been calling for advice from the GP after hours. Staff interviewed said their calls were always answered by the person on call and that advice and assistance was available 24/7. An adequate amount of food, water, and medical supplies for up to 36 residents plus staff was being stored on site. This meets the Ministry of Civil Defence and Emergency Management recommendations for the region. Equipment and resources for use during a power outage or environmental disaster were sighted and confirmed as available, for example access to a generator, a barbeque for cooking and additional blankets for warmth. Six monthly fire evacuation drills had been occurring. The most recent drill occurred on 13 July 2023. Firefighting equipment audits are carried out by the contracted fire security provided and a local fire officer attends at least one drill each 12 month period. The fire evacuation plan was reviewed and approved by Fire and Emergency Service NZ (FENZ) in April 2023 although there had been no changes to the building structure. The call bell system was witnessed to be functional during the audit and residents said staff responded to these in a timely way. Appropriate security arrangements are in place. Staff wear uniforms and name badges so that they are easily identifiable. Doors and windows are locked at dusk. All staff and visitors are asked to wear a mask when in close proximity to residents and/or when in the secure unit. All visitors are required to sign in and provide proof of identify if they are unknown to staff. Residents and staff said they were familiar with emergency and

		security arrangements.
Subsection 5.1: Governance The people: I trust the service provider shows competent leadership to manage my risk of infection and use antimicrobials appropriately. Te Tiriti: Monitoring of equity for Māori is an important component of IP and AMS programme governance. As service providers: Our governance is accountable for ensuring the IP and AMS needs of our service are being met, and we participate in national and regional IP and AMS programmes and respond to relevant issues of national and regional concern.	PA Low	The service was implementing an infection prevention programme developed by an infection control specialist provider. This was endorsed and approved by the owner/director. The infection prevention programme contributed to the safety of residents and staff. The infection prevention co-ordinator (IPC) advised that the specialist provider was available to provide expert knowledge, direction and advice to the service and director as required. Infection prevention policies and procedures directed the management of infection events using a stepwise approach and a multidisciplinary team appropriate. The IPC stated these policies and procedures would guide the management of an infection event. An opportunity for improvement has been identified regarding the escalation of infection reports and incidents to the governing body.
Subsection 5.2: The infection prevention programme and implementation The people: I trust my provider is committed to implementing policies, systems, and processes to manage my risk of infection. Te Tiriti: The infection prevention programme is culturally safe. Communication about the programme is easy to access and navigate and messages are clear and relevant. As service providers: We develop and implement an infection prevention programme that is appropriate to the needs, size, and scope of our services.	FA	The infection prevention (IP) programme implemented was suitable for the size and scope of the service provided. The programme was co-ordinated by a registered nurse (infection prevention co-ordinator), who was undertaking suitable training in infection control at the time of the audit. The IPC oversaw, implemented, monitored, and reported the IP programme. The IPC's line of report was to the facility manager (refer to 5.1.3). The IPC stated that the IPC role included input into procurement, building modifications, and other relevant policies and procedures. The IPC advised that support and expertise was available from the IP programme supplier and the local Te Whatu Ora. There was access to clinical records and diagnostic results. The IP programme, policies and procedures purchased met the requirements of this standard and reflected best practice. The programme contained documentation and references to verify that it had been developed in partnership with Māori and reflected Te Tiriti o Waitangi. The programme had been reviewed annually. Monthly reports were provided to the facility manager and in addition these

		had been formatted into graphs and were on display on the quality notice board (refer to 2.2.3). A current pandemic/infectious diseases response plan was documented and had been tested. Sufficient supplies of infection prevention resources and personal protective equipment (PPE) was available. Hand basins and hand sanitisers were readily available throughout the service. Signage pertaining to hand hygiene was sighted during the audit. Infection prevention education had been provided to staff during orientation and was a component of the annual education plan. Staff confirmed they had received infection prevention education during orientation and discussed the 'five moments' of hand hygiene (refer to 2.3.3). Single use devices were not reused, this was verified during staff interviews and by observation during the audit. Reusable shared equipment for example sphygmomanometers (blood pressure monitors), thermometers, and dressing scissors were decontaminated appropriately as per policy and the manufacturers recommendations. Appropriate materials for this process were observed during the audit, and staff discussed the procedure. Bedpans and urinals were sanitised after each use. The IPC stated that infection surveillance analysis is used to monitor the effectiveness of decontamination of reusable devices, reports viewed confirmed that no trends or issues were identified. The IP programme had a section relating to Māori cultural values. The section reflected the spirit of Te Tiriti O Waitangi and provided guidance to staff to ensure culturally safe practice. Staff interviewed confirmed they were aware of the policy, and provided examples of how culturally safe practices were implemented. Where educational resources were required to be given to residents in te reo Māori, these were accessed from Te Whatu Ora. Residents and family/whānau confirmed that staff had discussed with them infection control issues and precautions.

Subsection 5.3: Antimicrobial stewardship (AMS) programme and implementation The people: I trust that my service provider is committed to responsible antimicrobial use. Te Tiriti: The antimicrobial stewardship programme is culturally safe and easy to access, and messages are clear and relevant. As service providers: We promote responsible antimicrobials prescribing and implement an AMS programme that is appropriate to the needs, size, and scope of our services.	FA	There was an implemented antimicrobial policy that was appropriate to the size, scope and complexity of the service. The policy had been approved by the external infection control service and was a component of the IP programme. Reports were sighted that included the number and type of infections, with an analysis that included the antibiotic course prescribed, and the causative organism as identified by laboratory report. The reports were reviewed by the IPC and the acting facility manager to identify trends, or/and opportunities to reduce antimicrobial prescribing. The GP interviewed confirmed antibiotic prescribing occurred as per best practice guidelines sourced from Best Practice Advocacy Centre New Zealand (BPAC), and laboratory services. The IPC and the acting RN/facility manager had access to laboratory reports.
Subsection 5.4: Surveillance of health care-associated infection (HAI) The people: My health and progress are monitored as part of the surveillance programme. Te Tiriti: Surveillance is culturally safe and monitored by ethnicity. As service providers: We carry out surveillance of HAIs and multi-drug-resistant organisms in accordance with national and regional surveillance programmes, agreed objectives, priorities, and methods specified in the infection prevention programme, and with an equity focus.	FA	Surveillance of health care-associated infections was appropriate to the size and type of service. The surveillance programme was documented, and standard definitions were used relating to the type of infection acquired. Surveillance data that included ethnicity data was collected and reported to the RN/acting facility manager (refer to 5.1.3). Trends and opportunities to improve were considered by the IPC and the RN/acting facility manager. There were no trends identified in IPC documents sampled. The reports were presented in graph format and displayed on the quality notice board. Residents who developed an infection were informed, and family/whānau were advised. The GP was involved in the oversight and management of the resident while the infection was active. The process was culturally appropriate, and this was confirmed by residents and family/whānau. There had been no out breaks of infection in the current year.

Subsection 5.5: Environment The people: I trust health care and support workers to maintain a hygienic environment. My feedback is sought on cleanliness within the environment. Te Tiriti: Māori are assured that culturally safe and appropriate decisions are made in relation to infection prevention and environment. Communication about the environment is culturally safe and easily accessible. As service providers: We deliver services in a clean, hygienic environment that facilitates the prevention of infection and transmission of antimicrobialresistant organisms.	PA Moderate	A dedicated team of cleaning staff were onsite seven days a week for sufficient hours to carry out cleaning duties. Policies and procedures provided direction for staff to ensure that the cleaning processes were effective. The facility was observed to be clean, and the residents and family/whānau interviewed confirmed that the facility was kept clean and tidy. Material data safety sheets were available for staff to access as required. Cleaning trolleys were stored safely when not in use. An adequate supply of personal protective equipment (PPE) was available and included masks, gloves, aprons and goggles. Staff were observed using PPE. The onsite laundry is small but contained enough commercial machines to complete daily laundry loads and had a designated dirty and clean section. Designated laundry staff were on site seven days a week during the day and care staff continued to carry out laundry duties on evening and night shifts. An unnamed sanitising product was observed in the laundry cupboard which had been decanted into a container that previously held a food product. This was removed during the audit. The chemical dispensing system had been relocated to the staff room and the smells from the products was preventing staff from using the room for their breaks. Staff were going off site or sitting in their cars instead. An improvement is required in 5.5.1. Staff confirmed that they had completed safe chemical handling education. Family/ whānau confirmed that clothing was laundered appropriately, and they were satisfied with the service. Observation during the audit verified the resident's linen and clothing was clean and well maintained. The IPC confirmed that they had oversight of the facility testing and monitoring programme for the built environment. The disposal of rubbish and waste (including hazardous and infectious) met local authority requirements; however, the recording and storage of hazardous substances requires improvement.

Subsection 6.1: A process of restraint The people: I trust the service provider is committed to improving policies, systems, and processes to ensure I am free from restrictions. Te Tiriti: Service providers work in partnership with Māori to ensure services are mana enhancing and use least restrictive practices. As service providers: We demonstrate the rationale for the use of restraint in the context of aiming for elimination.	FA	Ohope Beach Care has a philosophy and practice of no restraint which is endorsed by the owner of the service. There are policies and procedures in place which meet the requirements of this standard and provide guidance on the safe use of both restraints if these are ever required. No restraint has been used for over 10years. There are processes to follow for reporting restraint if this is required. The monthly reports to the owner always state 'no restraint' An RN is nominated as the restraint coordinator. This person 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 their role and responsibilities. Alternatives to restraint interventions being used are de-escalation, provision of a low stimulus environment, low beds, and sensor mats. Interviews, documents reviewed, visual inspection and other observations, during the days of audit, confirmed there were no residents using restraint. All of the residents who do not have dementia can come and go as they please.

Specific results for criterion where corrective actions are required

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

Criterion can be linked to the relevant subsection by looking at the code. For example, Criterion 1.1.1 My service provider shall embed and enact Te Tiriti o Waitangi within all its work, recognising Māori, and supporting Māori in their aspirations, whatever they are (that is, recognising mana motuhake) relates to subsection 1.1: Pae ora healthy futures in Section 1 Our rights.

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.6.4 I shall be provided with the time I need for discussions and decisions to take place.	PA Low	Resident meetings were not being held each month as required by policy and procedure. The minutes from one meeting held in September 2023 contained matters of concern raised by residents for example, meal temperatures and portion sizes. Although some staff were aware of the concerns raised by residents, actions to resolve these matters had not been implemented or responded to at the time of the audit.	There was no evidence that residents were being provided with regular and reliable opportunities for discussion or decision making. There has only been one residents meeting held year to date. Actions related to concerns raised had not addressed.	Ensure resident meetings are held regularly, documented and that actions arising are implemented. 180 days
Criterion 1.8.3 My complaint shall be addressed and resolved in accordance with the Code of Health and Disability	PA Moderate	There was no auditable record of complaints or concerns raised since the surveillance audit in December 2021. The complaints register was not being maintained. Verbal complaints made by	Management of complaints has not been occurring in accordance with the Code or the organisations policies and procedures.	Ensure the management of complaints adheres to the Code and the organisations policies and procedures.

Services Consumers' Rights.		family/whānau members to the director had not been recorded. Seven other concerns submitted by staff and residents were recorded on incident/accident forms. There was no evidence these had been acknowledged, investigated or resolved. The previous complaint form had been replaced by a 'Korero Mai' feedback form and was displayed at reception, however staff, residents and whānau had not been advised about how to use this. On the days of audit, staff attached this feedback form to the previously used complaints and compliments form which provides information about the process and advocacy contact numbers. These were made to be clearly visible, and together the forms provide a Māori friendly approach. Māori residents and whānau said they had no hesitation in raising concerns. Staff meeting minutes and monthly reports to the director (which were not being sent to the director) did not mention complaints or concerns raised and therefore were not being used as opportunities for learning.		90 days
Criterion 1.8.4 I am informed of the findings of my complaint.	PA Moderate	Although interviewees spoke about raising concerns and complaints, no record of these could be found. Nothing had been entered into the complaints register since 2021, and there was no evidence that verbal or documented concerns had been formally or informally acknowledged, investigated	There was no evidence of communication with complainants or that concerns and complaints raised had been resolved.	Ensure that complainants are communicated with and advised of outcomes from complaint investigations. 90 days

		and addressed. There was no evidence of communication with complainants or that concerns and complaints raised had been resolved.		
Criterion 2.1.10 Governance bodies shall have demonstrated expertise in Te Tiriti, health equity, and cultural safety as core competencies.	PA Low	The owner/director who is a sole trader, said they had not undertaken any training in Te Tiriti o Waitangi, health equity or cultural safety. This person was not familiar with all the governance obligations under Ngā paerewa	The owner has not undertaken any learnings related to Te Tiriti o Waitangi, heath equity or cultural safety.	That the director undertakes learning and develop understanding and expertise in Te Tiriti o Waitangi, health equity and cultural safety. 180 days
Criterion 2.1.11 There shall be a clinical governance structure in place that is appropriate to the size and complexity of the service provision.	PA Moderate	The integrity of the existing quality and risk management system has been compromised by not implementing the methods described in the system or the policies which provided evidence-based care and ways to measure effectiveness. The organisation has lapsed in conducting internal (clinical) audits, prioritising quality improvement and patient safety including effective management of clinical risks, providing suitable and reliable staff education and training and ensuring there is an open, transparent and learning culture. Risk management, effective multidisciplinary teamwork, clinical leadership for quality and safety and the measuring of clinical processes and outcomes has ceased due to the infrequency and effectiveness of staff and quality improvement meetings, and the use of	There is no clinical governance structure or shared responsibility and accountability for the culture of engagement in resident safety and continuous quality improvement.	Implement suitable and appropriate methods for management, registered nurses and other staff to work together to improve and be held accountable for the quality and safety of the services they provide. 90 days

		data to identify variation. Staff reported they have not felt involved or understood the changes being made, and limited resident and whānau engagement and service co-design in the past 12 to 18 months.		
Criterion 2.1.2 Governance bodies shall ensure service providers' structure, purpose, values, scope, direction, performance, and goals are clearly identified, monitored, reviewed, and evaluated at defined intervals.	PA Low	The business goals documented for 2023 included development of a sensory garden, staff training in Te Tiriti o Waitangi and staff education. The goals were not clearly described, lacked measurable objectives and step by step processes for implementation. These were not delegated and there was no evidence they were being reviewed and evaluated for progress. The 2023 business goals were not being monitored, reviewed and evaluated for progress.	The 2023 business goals were not being monitored, reviewed and evaluated for progress.	Implement specific, measurable, relevant and appropriate business goals and ensure these are monitored, reviewed and evaluated regularly. 180 days
Criterion 2.1.3 Governance bodies shall appoint a suitably qualified or experienced person to manage the service provider with authority, accountability, and responsibility for service provision.	PA High	The person appointed as acting facility manager commenced employment as a temporary registered nurse/clinical leader on 02 September 2023. The acting manager was being supported by another registered nurse, administrators and the IT manager who had been in their roles for more than 24 months. The appointee is clinically competent and has sufficient experience in the provision of safe and suitable care of older people, including those with dementia. Although the acting manager demonstrates critical	The acting facility manager is a registered nurse, who is clinically competent and experienced in age care and dementia care but is not experienced in the management of an aged care facility.	Ensure the facility manager is suitably qualified and experienced. 30 days

		thinking, a practical approach and good communication skills, they are not experienced in managing an aged care facility and have been nursing overseas. The acting manager is not fully familiar with all New Zealand regulations, legislation, these standards and the current aged care health sector. Information related to this was conveyed to the local health of older people portfolio manager, the owner/director and a member of HealthCERT the certification body for Manatū Hauora Ministry of Health during and after this audit.		
Criterion 2.1.5 Governance bodies shall ensure service providers deliver services that improve outcomes and achieve equity for Māori.	PA Low	Staff stated they have attended some recent training and education related to improving outcomes and achieving equity for Māori, but there was limited evidence to verify this. Interview with the owner/director revealed they were not informed or fully understood their responsibility to ensure staff knew how to deliver equitable services to Māori residents in ways that improved their outcomes.	There were no systems in place that enabled the director to ensure that service delivery led to improved outcomes and equity for Māori.	That the owner/director establishes methods for monitoring and ensuring services are delivered in ways that improve health outcomes and achieve equity for Māori. 180 days
Criterion 2.1.6 Governance bodies shall ensure service providers deliver services that improve outcomes and achieve equity for tāngata whaikaha people with	PA Low	Interview with the owner/director showed they were not informed or fully understood their responsibility to ensure staff knew how to deliver equitable services for tāngata whaikaha in ways that improved their outcomes.	There were no systems in place that enabled the owner/director to ensure that service delivery led to improved outcomes and equity for tāngata whaikaha people with disabilities.	That the owner/director establish methods for monitoring and ensuring services are delivered in ways that improve health outcomes and achieve equity for tāngata whaikaha.

disabilities.				180 days
Criterion 2.1.7 Governance bodies shall ensure service providers identify and work to address barriers to equitable service delivery.	PA Low	Although no perceivable barriers to equity were identified during the audit, the service provider had not considered or identified what barriers to equitable service delivery might exist or present in the future.	There were no systems or methods for identifying and eliminating barriers to equitable service delivery.	Establish methods for identifying and addressing barrier to equitable service delivery. 180 days
Criterion 2.1.9 Governance bodies shall have meaningful Māori representation on relevant organisational boards, and these representatives shall have substantive input into organisational operational policies.	PA Low	The owner/director was not familiar with the requirement to have Māori representation into organisational procedures. A member of staff said they had made some preliminary arrangements for kaumātua and kuia services, but these had not been fully implemented. The pre audit document review revealed an intention to establish te roopu/Māori staff group, but only one of the staff spoken to had knowledge of this.	There were no evidence of Māori representation and input to service delivery or operational practices.	Implement a method for demonstrating engagement with suitable Māori representatives who have regular input and oversight of cultural procedures. 180 days
Criterion 2.2.2 Service providers shall develop and implement a quality management framework using a risk-based approach to improve service delivery and care.	PA High	Policies and procedures that describe all potential internal and external risks and corresponding mitigation strategies were not being implemented. There was limited evidence of effective risk management for example, no current risk management plan, no hazards register, no internal audits since May 2023 or other methods for identifying and monitoring overall risk, such as surveys of residents, whānau and staff. New and ongoing risks were not being	The previous risk-based approach for identifying and mitigating risk has not been adhered to. This has led to significant gaps in the overall risk management system.	Ensure that an effective risk management system is implemented to identify, monitor and mitigate all potential internal and external risks that threaten safe service delivery and care. 30 days

		reliably notified to all staff. The staff and quality improvement meetings held since 2021 did not follow documented processes, or record evidence that quality and risk matters had been discussed. A new method for documenting risks based on day-to-day incidents was introduced from February to March 2023. This was superseded by a complex incident register which recorded and rated incidents month by month between April to June 2023. There was no evidence of trend analyses. The corrective actions to prevent or minimise future incidents lacked detail of implementation. Staff said these reports were not shared with them, nor were the incidents adequately discussed at staff meetings. This finding is linked to criterion 2.2.5. Clinical staff had already re-established a system for collating and analysing trends to identify clinical risks impacting residents. The overall service has been exposed to risk for some time, as demonstrated by the number of findings identified at this audit. A significant number of clinical and care staff had resigned. The MHOPS team had visited the secure unit in 2022 to assess the clinical status of some residents upon hearing concerns expressed in the community. This resulted in some residents being transferred to facilities more suited to their needs. A few of the residents in the secure unit had been identified by the RN/acting facility manager as requiring reassessment for		

		their safety and the safety of others prior to the audit. Action/referral and enquiries had been initiated. Other areas of risk identified at audit, such as storage of chemicals, orientation, the competency of staff and overall management of service delivery need to be addressed. This finding is linked to criteria in 2.3.3, 2.4.4, and 5.5.1		
Criterion 2.2.3 Service providers shall evaluate progress against quality outcomes.	PA Moderate	A current (and relevant to the service) quality plan with clearly identified goals has not been developed since 2021. There was no systematic or documented approach to quality monitoring such as an action plan with measurable outcomes. As reported in criterion 2.2.2, internal audit activity ceased in May 2023, staff meetings have not been used to share quality data and there have been limited opportunities for staff, residents and their families/whānau to provide feedback.	Quality outcomes cannot be evaluated as there were no quality goals, action plans or methods for measuring progress.	Implement methods for evaluating progress against quality outcomes. 90 days
Criterion 2.2.4 Service providers shall identify external and internal risks and opportunities, including potential inequities, and develop a plan to respond to them.	PA Moderate	Organisational strengths, weaknesses, opportunities and threats (SWOT) analysis was documented but there was no evidence that issues identified in this were being acted on. This SWOT analysis, or any other plan did not specifically identify potential inequities.	The process for identifying risks and opportunities was limited in its scope, did not identify potential inequities and has not been acted on.	Identify all external and internal risks and opportunities, including potential health and service delivery inequities, and develop a plan that responds to them. 90 days

Criterion 2.2.5 Service providers shall follow the National Adverse Event Reporting Policy for internal and external reporting (where required) to reduce preventable harm by supporting systems learnings.	PA Moderate	Incident and accident data is being reliably documented and reported upward in a timely manner by all levels of staff. A sample of incident reports revealed that family/whānau, RN or general practitioner (GP) were notified as needed and that neurological assessments following unwitnessed falls or falls involving the head, were occurring according to best known practice. As reported in criterion 2.2.2, the documented policy, procedure and system for effective incident management has not been followed. Two new methods for logging incidents and accidents had been ineffective by not including all adverse event reports and not analysing the reports for wanted or unwanted trends. The incident registry set up in April 2023 did not contain sufficient or clear detail about the event or how to prevent recurrence and it did not link with other systems such as staff communication, essential reporting, quality governance and improvements in safety and care. Clinical staff recently directed an administrator to upload all resident related incidents reported between January 2023 and year to date, in ways that can be collated according to categories. This process is still under development and the data is still to be formally analysed for wanted and unwanted clinical trends, except for resident infections and antimicrobial	Incident and accident data is being collated but is not yet being used to support systems learning.	Continue to develop systems for analysing all reported incidents and accidents and use the data to facilitate staff and system wide learning. 90 days

		stewardship where the collated data presents an easy-to-understand overview and was already on display in the home. Several other incident reports for the period were discovered during the audit and needed to be uploaded and tabulated. These included overlooked resident incidents, staff accidents, equipment failure and environmental incidents. Preliminary review of the incident data revealed a moderate to high incidence of medicine errors being reported each month. These were being mitigated by the RN acting manager who had initiated actions to prevent more incidents (such as delegating medicines administration to the senior health care assistant) and re assessing staff competency in safe medicine administration. This person was also trying to recruit more care staff (nursing students) to administer medicines on all shifts. Clinical staff have re-established an efficient and timely method for collecting and analysing data that meets the National Adverse Event Reporting Policy, which now needs to be used to inform quality and risk management, and leads to improving staff knowledge, clinical care and safety.		
Criterion 2.2.8 Service providers shall improve health equity	PA Low	Staff attended training about achieving health equity in July 2023, but a large percentage of those staff are no longer employed. Quality and risk	There are no systems identified or established for measuring and improving health equity within the	Determine methods for analysing and measuring improvements in health

through critical analysis of organisational practices.		management systems have been disrupted including internal auditing and service performance monitoring. Methods for identifying inequity and measuring improvements have not been established.	service.	equity. 180 days
Criterion 2.3.1 Service providers shall ensure there are sufficient health care and support workers on duty at all times to provide culturally and clinically safe services.	PA Moderate	Although staff levels appear to be sufficient, the acuity and individual needs of some residents and overtime hours being worked, plus the corrective actions in this subsection indicated a need to review the provision of staff on all shifts. Concerns were expressed about the ability to maintain enough skilled and experienced staff in the dementia unit due to one resident's aggressive behaviour and some staff not being willing to endanger themselves. On the days of audit, the RN/acting manager was endeavouring to appoint more medication administration competent staff for all shifts.	Not all staff in the dementia unit had the skills, and experience to competently manage resident acuity.	Ensure there are enough skilled and experienced staff on site to provide clinically safe services. 90 days
Criterion 2.3.2 Service providers shall ensure their health care and support workers have the skills, attitudes, qualifications, experience, and attributes for the services being delivered.	PA Moderate	The new electronic system for logging staff records was not being used to its full capacity. The information uploaded was not complete or current. Evidence of how many staff were employed for what roles, and what their qualifications and experience was needed to be derived manually on the days of audit. Staff educational achievements were not being reliably recorded. Levels of	There was no coherent and readily accessible system for determining how many staff were employed, and what their current qualifications and experience were. This is in breach of the ARCC agreement	Implement a readily accessible system that effectively and accurately reflects the current composition of all staff, along with their skills, experience, qualifications, attitude and attributes. Ensure that all staff working in the dementia unit has achieved unit standards

		educational achievement for care staff had to be determined during the audit by calling each staff member. It was not clear that all staff working in the dementia unit had commenced or completed the limited career path (LCP) modules for dementia as required in clause E4.5f of the ARCC agreement. This improvement links to findings in subsection 2.4. .		23920 to 23923 within 18 months of employment. 90 days
Criterion 2.3.3 Service providers shall implement systems to determine and develop the competencies of health care and support workers to meet the needs of people equitably.	PA Moderate	Continuing education for staff had not been fully implemented and there was no cohesive or integrated system for recording individual training/competencies.	The electronic staff records system did not contain all the information necessary to ascertain staff competencies.	Implement an effective system for determining and developing staff competencies. 90 days
Criterion 2.3.4 Service providers shall ensure there is a system to identify, plan, facilitate, and record ongoing learning and development for health care and support workers so that they can provide high-quality safe services.	PA Moderate	There was no clear evidence of a planned and coordinated system for staff education and training, Provision of staff learning, and development was ad hoc and not integrated with an overall plan, performance appraisals or methods for determining each staff members learning needs.	Staff educational achievements were not being accurately recorded. There was no reliably coordinated or integrated system for identifying, planning, delivering and recording staff training and education.	Implement a planned and coordinated system for identifying, planning, delivering and recording staff learning and development. 90 days
Criterion 2.3.5 Service providers shall assist with training and support for people and service providers to	PA Low	There was no clear evidence that this criterion was known about or that attempts had been made to provide training and support. Staff had attended a training session provided by the local representative from the Nationwide	It was uncertain that staff had attended training or been informed about how to maximise residents and whānau participation in the service.	Ensure that staff are provided with training on how to support residents and whānau participation in the service.

maximise people and whānau receiving services participation in the service.		Advocacy service in July 2023, but there was no record of what the training covered.		180 days
Criterion 2.3.6 Service providers shall establish environments that encourage collecting and sharing of high-quality Māori health information.	PA Low	Although attempts had been made to establish kaumātua support and staff had attended some training related to culturally safe care, the service provider had not established methods for ensuring that Māori health information was available.	There were no methods or systems in place for identifying, collecting and sharing evidence based and current Māori health information.	Encourage the collecting and sharing of high-quality Māori health information. 180 days
Criterion 2.3.7 Service providers shall invest in the development of organisational and health care and support worker health equity expertise.	PA Low	Some training related to health equity occurred in July 2023 but there was no recorded description of the content. Staff interviewed were not able to articulate what was meant by health equity.	Some training related to health equity occurred in July 2023 but there was no recorded description of the content. Staff interviewed were not able to articulate what was meant by health equity. There was no recorded description about the content of the health equity education provided in July 2023, or any process for assessing staff understanding or expertise.	Ensure that all staff understand the principles and practices of health equity. 180 days
Criterion 2.3.8 Support systems promote health care and support worker wellbeing and a positive work environment.	PA Moderate	Staff interviews revealed they were not feeling safe at work and that many other staff had left because of this. There was no evidence that staff were being recognised or supported in their work efforts. Records of staff concerns, and general disgruntlement were seen in meeting minutes, and incident reports which had not been addressed.	There has been an overall lack of support or implementation of coherent systems which promote staff wellbeing or positivity in the workplace.	Implement processes which promote staff wellbeing and a positive work environment. 90 days

		Apart from informal collegial support there was no evidence of a formal debrief or check on staff wellbeing following the recent sudden death of a visitor. This finding is linked to criterion 2.4.7		
Criterion 2.4.1 Service providers shall develop and implement policies and procedures in accordance with good employment practice and meet the requirements of legislation.	PA Moderate	Information about staff had been uploaded to the new electronic record system (Employsure/Bright HR) but not all the necessary information was included. Job descriptions were missing in four of eight records and only the last signed page of the employment agreements had been scanned into the system. There was no record of interviews or reference checks in the records of three new staff members. Police checks had been completed. Orientation and performance appraisals were not being reliably completed.	None of the eight staff records sampled contained all the information required to confirm good employment practice and adherence to New Zealand employment legislation.	Ensure that evidence of recruitment (interviews, reference checks) qualifications, job descriptions, and that the entire signed employment agreements held for each staff member. 90 days
Criterion 2.4.2 Service providers shall ensure the skills and knowledge required of each position are identified and the outcomes, accountability, responsibilities, authority, and functions to be achieved in each position are documented.	PA Moderate	Four of the eight staff records sampled did not have job descriptions attached. One staff member who had been employed as an IT manager for 18 months did not have a job description and their role or position had not been clarified verbally or in writing.	Four of the eight staff records sampled did not have job descriptions attached. One staff member who had been employed as an IT manager for 18 months did not have a job description and their role or position had not been clarified verbally or in writing. Three of the eight staff files sampled did not have job descriptions attached. One staff member who had been employed as an IT manager had never had	Ensure all staff employed have position descriptions, and that they understand their roles, functions, accountabilities and responsibilities. 90 days

			their position clarified.	
Criterion 2.4.3 Professional qualifications shall be validated prior to employment, including evidence of registration and scope of practice for health care and support workers.	PA Moderate	There was no documented record of regulated staff current membership with their regulatory body being held. Both RNs produced evidence of current APCs during the audit. Evidence of other health practitioners practicing certificates, such as the dispensing pharmacist, and general practitioner were not found. There was no system for validating and recording each health care assistant's level of educational achievement. When records of their qualifications could not be found in the system, they were contacted during the audit to determine this.	Evidence of staff and allied health professionals' registration and scope of practice was not recorded.	Maintain up to date records of regulated staff and health professionals who 90 days
Criterion 2.4.4 Health care and support workers shall receive an orientation and induction programme that covers the essential components of the service provided.	PA Moderate	Four of the eight staff files sampled did not contain evidence that orientation was completed. Three of these files were new staff. Two incident reports received from staff about other staff described concerns about a lack of orientation or introduction to the service. This was further confirmed by interviews with a range of staff. The IT manager stated that they ensured new staff were taken through health and safety and essential emergency systems. Cleaning, laundry and kitchen staff had been orientated and instructed in the use of equipment, personal protective equipment (PPE) and their day-to-day tasks. Interviews and staff	New staff were not being adequately orientated and inducted at the start of their employment.	Ensure all new staff complete orientation and are inducted in ways that ensure they understand their roles, obligations and responsibilities and the essential components of service delivery. 90 days

		meeting minutes revealed that a few existing staff were dissatisfied with being delegated responsibility for training and inducting new staff.		
Criterion 2.4.5 Health care and support workers shall have the opportunity to discuss and review performance at defined intervals.	PA Moderate	Interview with one senior staff member revealed they had not been offered a performance appraisal in the18 months they had been employed. Only one of the eight staff files sampled contained evidence of a completed performance review. Three files contained self-assessments submitted by the staff member but there was no evidence these had been considered by the person they were reporting to or that performance discussions had taken place. The service policy states that new staff would be offered a review of their performance after 90 days and annually thereafter. There was no evidence of 90-day reviews having occurred with new staff, and those interviewed were still in their 90 day period.	There was no evidence of annual performance appraisals or 90-day post-employment reviews occurring.	Ensure all staff members are given an opportunity to discuss and review their performance according to the intervals described in policy. 90 days
Criterion 2.4.6 Information held about health care and support workers shall be accurate, relevant, secure, and confidential. Ethnicity data shall be collected, recorded, and used in accordance with Health	PA Low	The information was being maintained as confidential and secure in the electronic database which is only accessible to delegated service leaders. Apart from information contained in curriculum vitae (CVs) or immigration data, there was no record of staff	The ethnicity of staff had not identified, collected or recorded as required.	Ensure that information held about staff is accurate and includes all the required information. 180 days

Information Standards Organisation (HISO) requirements.		ethnicity.		
Criterion 2.4.7 Health care and support workers shall have the opportunity to be involved in a debrief and discussion, and receive support following incidents to ensure wellbeing.	PA Low	Apart from informal collegial support there was no evidence of a formal debrief or check on staff wellbeing following the recent sudden death of a neighbouring tenant who was visiting, specifically for the staff member that the deceased person had collapsed on. This finding is linked to criterion 2.3.8	Policies and procedures for determining staff health and wellbeing were not being implemented. The support provided to staff following stressful incidents, such as the sudden death of a visitor recently, was informal.	Ensure all staff have the opportunity to debrief following stress incidents and implement systems for determining staff health and wellbeing. 180 days
Criterion 3.1.2 There shall be clearly documented processes for determining a person's entry into a service.	PA Moderate	Staff stated they were not always aware of a resident's pending admission, nor did they have any knowledge of the resident's needs or abilities. Six out of the seven clinical files sampled did not include a Needs Assessment Service Coordination (NASC) referral, or documentation regarding the resident's contract type, and/or care requirements. During the audit staff were observed to be contacting and liaising with multiple services and family/whānau to gather more detailed information about the needs of two residents in the dementia unit. One of the residents had been admitted from another facility after multiple meetings between the resident's case manager, the local MHSOP team leader and the previous facility manager along with the service operational/compliance manager. The RN/acting facility manager had	The admission process was not implemented consistently.	Ensure that the service clinical leaders are involved in all decision making about potential residents' entry to the service. 90 days

		requested a reassessment of this person's service needs due to ongoing behavioural issues, aggression, their mobility and long term diagnosis, which will likely require a level of care that Ohope Beach Care cannot provide. Clinical staff were not included in determining whether the resident could be suitably and safely cared for in the facility. Another resident who had previously been admitted to the rest home for respite short stay, was not able to be safely contained within the rest home due to wandering and had returned to the family for reassessment. On day two of audit the resident was readmitted to the dementia unit. Available documents did not provide clarity regarding the contract the resident had been admitted under of their planned length of stay. Clinical staff had not been involved in planning the resident's admission as required.		
Criterion 3.2.1 Service providers shall engage with people receiving services to assess and develop their individual care or support plan in a timely manner. Whānau shall be involved when the person receiving services requests this.	PA Moderate	Four clinical records were without documentation to confirm that initial interRAI assessments and a long-term care plan had been completed within the required 21-day time frame. New residents were not always seen by the GP/NP within five working days of admission as required by the Age-Related Residential Care agreement.	New residents were not being seen by the GP with five working days of admission.Not all interRAI assessments and long-term care plans had been completed within 21 days of admission as required in clause D16.2 of the Age-Related Residential Care (ARRC) service agreement.	Ensure new residents are seen by the GP and that interRAI assessments and care plans are completed within the required timeframe. 90 days

Criterion 3.2.3 Fundamental to the development of a care or support plan shall be that: (a) Informed choice is an underpinning principle; (b) A suitably qualified, skilled, and experienced health care or support worker undertakes the development of the care or support plan; (c) Comprehensive assessment includes consideration of people's lived experience; (d) Cultural needs, values, and beliefs are considered; (e) Cultural assessments are completed by culturally competent workers and are accessible in all settings and circumstances. This includes traditional healing practitioners as well as rākau rongoā, mirimiri, and karakia; (f) Strengths, goals, and aspirations are described and align with people's values and beliefs. The support required to achieve these is clearly documented and communicated; (g) Early warning signs and risks that may adversely affect a person's wellbeing	PA High	Clinical records did not consistently record the residents' monthly weight or vital signs. Not all staff were able to discuss the early warning signs of a deteriorating resident or discuss the escalation pathway. Senior staff stated that at times residents do not have vital signs recorded out of hours as required by the care-plan. They also advised that they are not always advised when a resident's condition changes, for example, has vomiting and/or diarrhoea.	Early warning signs of deterioration or development of conditions that impact a resident's wellbeing were not always documented or escalated.	Ensure early warning signs are reported, documented and escalated appropriately. 90 days

are recorded, with a focus on prevention or escalation for appropriate intervention; (h) People's care or support plan identifies wider service integration as required.				
Criterion 3.2.5 Planned review of a person's care or support plan shall: (a) Be undertaken at defined intervals in collaboration with the person and whānau, together with wider service providers; (b) Include the use of a range of outcome measurements; (c) Record the degree of achievement against the person's agreed goals and aspiration as well as whānau goals and aspirations; (d) Identify changes to the person's care or support plan, which are agreed collaboratively through the ongoing re-assessment and review process, and ensure changes are implemented; (e) Ensure that, where	PA High	Two clinical records contained documentation dated two months ago stating that a change in the resident's level of care was required. However, at the time of the audit there was no evidence to confirm that an updated interRAI assessment had been completed, or that the NASC had been notified.	InterRAI reviews and resultant referrals to the NASC in response to a change in health care needs were not always completed in a timely manner.	Ensure referrals to the NASC for a review of health care needs occurs as soon as practicable, 90 days

progress is different from expected, the service provider in collaboration with the person receiving services and whānau responds by initiating changes to the care or support plan.				
Criterion 3.3.1 Meaningful activities shall be planned and facilitated to develop and enhance people's strengths, skills, resources, and interests, and shall be responsive to their identity.	PA Moderate	During the audit it was observed that some residents in both the rest-homes and the dementia unit spent time in the lounge without engaging in an activity. Family and whānau stated that they had noticed there were minimal activities available for the residents to take part in. They advised that activities such as tapping balloons, playing skittles, bowls or dominoes was not being offered frequently enough to meet the resident's needs. Staff interviewed confirmed that the activities programme did not consistently meet the needs of the residents. The GP said the activities programme did not always engage the residents to the extent they required.	The activities program does not consistently enhance and develop each resident's skills, strengths and interests.	Ensure that all residents are consistently provided opportunities to engage in meaningful activities that enhance and develop their interests, strengths and skills. 90 days
Criterion 5.1.3 There shall be a documented pathway for IP and AMS issues to be reported to the governance body at defined intervals, which includes escalation	PA Low	The infection co-ordinator submitted reports to the facility manager, however there was no evidence that these had been presented to the director. The director confirmed no infection control reports or incidents had been provided.	Infection control and antimicrobial surveillance (AMS) issues including significant infection incidents were not being reliably reported up to the director.	Ensure infection control and AMS issues and other significant IP information is reported to the director/owner at regular intervals.

of significant incidents.				180 days
Criterion 5.5.1 Service providers shall ensure safe and appropriate storage and disposal of waste and infectious or hazardous substances that complies with current legislation and local authority requirements. This shall be reflected in a written policy.	PA Moderate	The pre audit document review revealed there was no current hazardous substances register, although staff knew what products were in use and stored on the property. An unnamed container of product, assumed by staff to be 'DIPit' a caustic sanitising agent, was found in a laundry cupboard. This had been decanted into a container that was labelled as gravy mix. The product was disposed of on the day of audit. The chemical product dispensing system had been relocated and installed on the wall of the small staff room. The smell of chemicals was pervasive, even with the doors open and prevented staff from being able to use the room for their tea or meal breaks. The system was apparently shifted due to a leak in the cleaner's cupboard and the staff room was planned to be relocated but this had not occurred.	There was no hazardous substance register. A hazardous bleaching/sanitising chemical/agent found in the laundry had been decanted into container previously used for food. The chemical decanting system is inappropriately installed in the only staff room which has prevented them from being able to be in there for periods of time.	Ensure all hazardous substances including chemicals used on site are documented on a hazards register. Ensure all chemicals are stored in suitably and clearly marked containers that accurately describe the contents. Ensure staff have access to a suitable and pleasant area for their work breaks 90 days

Specific results for criterion where a continuous improvement has been recorded

As well as whole subsections, individual criterion within a subsection 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 subsection by looking at the code. For example, Criterion 1.1.1 relates to subsection 1.1: Pae ora healthy futures in Section 1: Our rights.

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

No data to display

End of the report.