Ohope Beach Care Limited - Ohope Beach Care

Introduction

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

The audit has been conducted by HealthShare Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	Ohope Beach Care Limited
Premises audited:	Ohope Beach Care
Services audited:	Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 8 December 2021 End date: 8 December 2021

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: 36

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

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

General overview of the audit

Ohope Beach Care Limited, trading as Ohope Beach Care, provides rest home and dementia level care for up to a maximum of 36 residents. Day to day operations/service delivery are overseen by a facility manager who reports to a director. The only significant change since the previous certification audit in 2019 is a change in the clinical nurse leader.

This surveillance audit was conducted against a subset of the Health and Disability Services Standards and the service's agreement with their District Health Board (DHB). The audit process considered the organisations policies and procedures, residents' and staff files, observations and interviews with residents, family members, the facility manager, staff, and a general practitioner (GP). The GP, residents and families spoke positively about the care provided.

There were no areas identified that required improvement.

Consumer rights

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

Communication between staff, residents and their families is open and transparent. There is access to interpreting services if required.

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

Organisational management

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

An annual strategic plan describes the scope, direction, goals, values and mission statement of the organisation. The director and FM are monitoring all aspects of the services provided.

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

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

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.

The provision of all aspects of clinical care, including assessment, planning, interventions, and evaluation was provided in a timely manner by staff with suitable knowledge and skills. The activities programme is available 24 hours per day, seven days per week. The programme is suitable for the service type. Medicine management practices are in line with current legislation, regulations and best practice. Resident meals are prepared on site. The service has a current food plan and menus have been approved by a registered dietitian.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.

There was a current building warrant of fitness and there have been no changes to the structure of the building since the previous audit.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.

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

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

Infection prevention and control

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

The infection control programme is current and is based on current recommended practice and guidelines. The surveillance programme reflects the size and type of service, all data is analysed action plans developed where trends are identified.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	16	0	0	0	0	0
Criteria	0	41	0	0	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

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

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click here.

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	Complaint management processes and policies met the requirements Right 10 of The Code. Interviews confirmed there have been no complaint investigations by the DHB or the Office of the Health and Disability Commissioner. There were five complaints in the complaints register, three related to pharmacy errors which were incidents not complaints. The two other complaints were related to staff conduct. These were promptly investigated and effectively managed according to the information recorded about each matter. Residents and family members confirmed they knew what to do if they had a concern/complaint and said they had no reservations about approaching any staff member to raise these.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Residents and family members stated they were kept well informed about any changes to their or their relative's health status. They said they were advised in a timely manner about any incidents or accidents and outcomes of regular or urgent medical reviews. This was evident in incident reports and the residents' records sampled. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code of Health and Disability Services Consumers' Rights (The Code) . Family members confirmed they were invited to care review meetings where up to date care information is shared, and their input was sought. Staff knew how to access interpreter services, although reported this was rarely required due to all residents being able to speak English. There is a policy and procedure in place to guide staff on the process for seeking

		interpreter services when required.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Ohope Beach Care has agreements with the Bay of Plenty District Health Board (DHB) for Aged Related Residential Care and respite/short term care. The facility has a maximum capacity for up to 36 residents, comprising 11 rest home and 25 dementia beds. On the day of audit all beds were occupied. The business plan is developed and reviewed annually by the owner in consultation with the facility manager. This contains the direction, vision, mission statement, scope of services, objectives and an action plan. The manager submits written reports to the owner every second month and is in regular contact in between times. The monthly reports contain information about occupancy, service delivery issues and highlights, staffing information, maintenance, complaints and compliments, adverse events and internal audit outcomes. Review of the results from the March and August 2021 satisfaction surveys of residents and their families revealed a high degree of satisfaction. Resident feedback about some items of food on the menu was taken into consideration and changes were implemented. The service is managed by a facility manager (FM) who is a registered nurse with extensive clinical and managerial experience in age care. This person is suitably qualified with post graduate diplomas in health sciences, leadership and palliative care. The clinical nurse leader (CNL/RN) commenced employment in April 2021. This person has two years' experience working in memory care units. Both the FM and CNL are attending ongoing education related to their roles and each had completed at least eight hours of professional development in the last 12 months.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	Consideration of quality related documents and interview with the FM demonstrated the effectiveness of the quality and risk management systems. The quality and risk management plan clearly describes the overall approach to quality and risk and how service delivery and performance is monitored which includes regular internal audits. The policies and procedures are industry standardised and align with the Health and Disability Services Standards, legislative and contractual requirements. Quality data, such as incidents/accidents, infections, skin tears, falls, results of internal audits, complaints and service delivery improvements are analysed and discussed with all levels of staff at weekly and monthly meetings. There is evidence of actions being implemented to good effect when service deficits are identified. The service continues to demonstrate a commitment to quality improvement. Examples are the introduction of daily skin moisturizing for all residents to maintain skin integrity, elimination of staff injuries, development of vegetable gardens which residents access and improvements to the environment, such as new carpets. Ohope

		Beach Care have also started benchmarking their quality data with five other aged care facilities. Residents and family members interviewed confirmed they are consulted about services and are kept updated through regular group and/or one to one meetings and via the service newsletters. The organisation's quality and risk management plan and associated emergency plans, identify current actual and potential risk to the business, service delivery, staff and/or visitors' health and safety. The risk management plans are reviewed annually and as needed when new risks are identified. Environmental risks are communicated to visitors, staff and residents verbally or by signs. Review of a range of staff meeting minutes showed that health and safety, including new risks including resident related risks, are discussed. The organisation has progressed from silver to gold with the Bay of Plenty DHBs 'Workwell- Standard Accreditation' program. This program provides a comprehensive and practical approach to health and safety in the workplace.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	The sample of incidents/accident records contained a clear account of the event, actions taken at the time and any ongoing actions, for example neurological observations after an unwitnessed fall and where changes had been made to prevent or minimise recurrence. Records showed that staff, families, the GP, the DHB or others who are impacted by an adverse event, are informed in a timely manner. Trends in adverse events are being monitored and reported back to staff and the owner at regular intervals. The FM understands essential notification reporting requirements. The only Section 31 report submitted to the Ministry of Health in the past 12 months was related to the change of clinical nurse leader (CNL) in June 2021. There had been no police investigations, coroner's inquests, or issues-based audits.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	Staffing policies and processes meet accepted employment practices and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs) where required. The sample of staff records confirmed the organisation's policies are being consistently implemented and records are maintained. Staff orientation includes all necessary components relevant to the role. Documents and interviews confirmed that a site-specific training plan is developed each year which includes mandatory training requirements. Review of the 2020-2021 plan and attendance records confirmed that staff are being provided with continuing education in subjects related to age care. A record of each staff member's training is recorded in their personnel files and is discussed with them during their performance appraisals. There are two approved Careerforce moderator/assessors on the staff. Care staff have either completed or commenced a New Zealand Qualification Authority (NZQA) education

		programme to meet the requirements of the provider's agreement with the DHB. All of the 27 care staff are on an educational pathway with Careerforce or have already achieved unit standards in care of older people. On the day of audit, 14 had achieved level four, six were on level three, and seven were on level two. Review of rosters and staff files confirmed that the RNs and all carers who work in the dementia unit have either attained or are progressing toward attaining the level four dementia qualification. The two registered nurses are trained and maintaining their annual competency requirements to undertake InterRAI assessments and the FM has management access to the system. The six staff records reviewed contained evidence of annual performance appraisals being completed.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week. Staffing levels are adjusted to meet the changing needs of residents. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of a three-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. There is an RN on site each morning shift seven days a week. Both RNs are employed for 32 hours a week. The FM becomes the RN on the floor when the other two RNs are rostered off. There are four carers rostered on each morning and afternoon shift and three at night. The FM/RN is on call after hours. All afternoon and night shift staff are maintaining a current first aid certificate.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	The medicine management policy is current and meets requirements. The service uses an electronic medication management system and a pharmacy pre-packaged medication system. All medication files sampled met legislative requirements. A medication round was observed and reflected best practice guidelines. Registered nurses and care staff who have completed a medication training programme and an annual competency assessment administer medications. This was verified by education records sampled. The GP confirmed that a satisfactory medication management system is in place, which includes three monthly reviews of each resident's medication. Medications are stored in a locked cupboard and/or in a medication locked trolley. There are two locked cupboards that store medication, one for the rest-home, and one for the dementia unit. The storage areas are temperature monitored and records sighted verified the temperatures were within acceptable ranges. There is one medication fridge which is temperature monitored, with records confirming the range was within recommended guidelines.

		The service does not use standing orders and no residents were self-administering medication. Controlled medications are stored and recorded as per legislative requirements. Specimen signatures are kept of all staff.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	All food is prepared in the onsite kitchen. The service caters for the individual requirements of all the residents, including those that have for example allergies, diabetes, gluten intolerance, or require soft foods, and/or thickened fluids. There is a summer and winter menu which has been approved by a registered dietitian. The kitchen was clean and organised with adequate supplies of fresh and canned foods. All stored food had the best before date identified and prepared food stored in the fridge was covered and dated. Cleaning records of appliances are kept, as are fridge and freezer temperature records. The food control plan is valid until September 2022. A daily diary of food provided to residents is maintained, along with temperature records. Food is available 24 hours per day for Dementia residents and any rest home residents that may require it. Residents and family members interviewed stated satisfaction with the food service.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Long-term care-plans sampled contained interventions that reflected the residents' needs and goals, and contributed to holistic care, meeting the physical, spiritual, cultural and emotional dimensions of the resident's wellbeing. All files sighted confirmed that the GP had reviewed the residents three monthly, or more frequently if required. Staff interviewed discussed the care interventions provided to residents and were cognisant of the resident's rights, safety and dignity when delivering interventions. Interviews with residents and family members confirmed that interventions were being delivered and met expectations. Short-term care plans contained documented interventions for residents who had an infection, or other short-term conditions. Dementia resident's files sampled, contained a care plan that addressed the needs of the residents over a 24 hour period. The service had adequate continence supplies on hand to meet the needs of the residents. Sufficient and appropriate dressing supplies were available to meet the requirements of the service. The GP was interviewed and confirmed that interventions provided to residents were appropriate to meet their needs. The GP also stated that medically recommended care interventions were implemented and that residents were referred in a timely manner for a medical assessment.

Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	The activities programme is managed and developed by a qualified diversional therapist (DT). Implementation of the programme is by the DT and a DT assistant. The DT or DT assistant are on site seven days per week, six hours per day. Outside of these hours caregivers have access to activities that entertain residents such as puzzles, books, card games. This was confirmed by care staff and family members interviewed. The programme is revised monthly and consistently includes activities to promote physical and intellectual skills. Resident attendance records are maintained and were sighted in all clinical files sampled. The programme is developed to meet the needs of the dementia residents, and the rest home residents take part in activities of their choosing. Volunteers visit the facility to support the programme, for example local musicians and bands perform and the residents sing along and/or dance. During the audit a band was playing for the residents. A ten-seater van is on site and residents go on community outings regularly. Residents also go out with family members as appropriate. Family members are encouraged to participate in the activities programme while visiting, and this was observed during the audit. Family members interviewed spoke positively about the programme. The DT meets each resident at admission and completes a social profile and then develops a plan based on the information obtained in the social profile, this was verified in files sampled. The activities care plans had been reviewed six monthly in collaboration with the resident, and a registered nurse. The activities care-plan was integrated within the resident's clinical record. Residents who chose not to join into group activities are offered/provided a one-to-one activity with the DT, which includes for example reading, playing cards, or completing a jigsaw.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	All long-term care plans sampled were evaluated six monthly, following an InterRAI assessment. Interviews with residents and their family confirmed that they had been involved in the evaluation and any subsequent modification to the care-plan. Short-term care plans were evaluated as appropriate to monitor response to the interventions and signed off as completed when the ailment had resolved. Where progress has been different from expected, the service consults with the GP, and further referral to an appropriate service provider or health professional occurs, for example a physiotherapist, dietician or other specialist service. This was confirmed by the clinical nurse leader and the GP.
Standard 1.4.2: Facility Specifications	FA	A current building warrant of fitness (BWOF) was publicly displayed and expires in October 2022. There have been no changes to the building structure or footprint since the previous audit.

Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.		Appropriate systems were in place to ensure the residents' physical environment and facilities were fit for their purpose and maintained.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	Surveillance of infection prevention and control includes monitoring of infection types and numbers. The data is captured and recorded manually by the registered nurses. The FM analyses the data and identifies trends and develops action plans in response to trends as required. The surveillance programme is appropriate to the size and complexity of the service. Data reports and subsequent analysis reports were sighted, which included the number and type of infections per month. Staff meeting minutes confirmed that the monthly data reports and trends, along with an action plan are shared at local level with all staff members. This was verified by staff interviewed. Surveillance data reports indicated that the infection prevention and control programme is effective, and this was confirmed by the GP.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Ohope Beach Care has a philosophy and practice of no restraint. There are policies and procedures in place which meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers if these are ever required. The FM who is the restraint coordinator provides regular education to staff on how to maintain a restraint free environment and demonstrated a sound understanding of the organisation's policies, procedures and practice and her role and responsibilities. Staff are also tested for their knowledge and understanding about restraint and enablers. Alternatives to restraint interventions being used are de-escalation, provision of a low stimulus environment, low beds, sensor mats, falls prevention program and increased staff vigilance. Interviews, documents reviewed, visual inspection and other observations, during the days of audit, confirmed there were no residents using restraint or enablers. 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 standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.