Orewa Beach View Retirement Home & Hospital Limited - Solemar

Introduction

This report records the results of a Partial Provisional 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 BSI Group New Zealand Ltd, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to Manatū Hauora (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 Manatū Hauora website by clicking here.

The specifics of this audit included:

Legal entity:	Orewa Beach View Retirement Home & Hospital Limited
Premises audited:	Solemar
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Dementia care
Dates of audit:	Start date: 12 June 2024 End date: 12 June 2024

Proposed changes to current services (if any): Solemar has notified HealthCERT of the intention to change the dementia beds to dual purpose beds for rest home and hospital level of care. The letter from HealthCERT confirming the request for changes (17 May 2024). The service has also converted a lounge that had not been used in the past to a two bedroom able to accommodate a married couple or two residents. This room was verified on the day of audit. There will be 30 rooms including two rooms being able to accommodate married couples or to operate as shared rooms. As discussed with HealthCERT, this will be counted as 32 beds within the HealthCERT database.

Total beds occupied across all premises included in the audit on the first day of the audit: 24

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 tātou 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.

General overview of the audit

Orewa Beach View Retirement Home and Hospital Limited trading as Solemar currently provides rest home, hospital, and secure dementia care services for up to 30 residents.

This partial provisional audit was conducted against a subset of the Ngā Paerewa Health and Disability Standard 2021. The audit process included the review of relevant policies and procedures, a review of resident records (to address specific shortfalls identified at the previous audit), staff files, observations, and interviews with management.

This partial provisional audit was completed to establish the level of preparedness for Solemar to change the use of the dementia beds to dual purpose beds (for rest home and hospital level care residents). A lounge that had not been well used in the past had also been renovated to be a bedroom that would accommodate two residents (either as married couple or as a shared room). This audit verified this room as fit for purpose for residents requiring hospital or rest home level of care. This audit has confirmed that the service wishes to open on the 30 July 2024.

Since the previous audit, the service has addressed shortfalls in relation to Māori representation at governance level, collation of entry, decline and ethnicity data; and family/whānau input to care planning.

This partial provisional audit identified shortfalls around informing the funder of two residents requiring hospital level of care who are currently remaining in the dementia unit and to the removal of locks off bedroom doors in the dementia unit. Shortfalls to be addressed prior to occupancy are to a non-secure unit once all residents requiring dementia care have been relocated to other facilities and to the fire evacuation scheme.

Ō tātou motika | Our rights

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Hunga mahi me te hanganga | Workforce and structure

The owner/administrator is supported by the facility/clinical manager. Both form the governance body. Governance is committed to improving pae ora outcomes and achieving equity. The management team have knowledge and expertise in Te Tiriti o Waitangi, health equity, and cultural safety. The business plan includes a mission statement and outlines current objectives and includes goals around dual purpose beds. A transition plan is in place to guide the conversion of the dementia unit to a non-secure dual purpose wing that links with the existing hospital wing.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practices. An orientation programme is in place for new staff. An education and training plan is implemented. Competencies are defined and monitored. Staff records are secure and staff ethnicity data is collected.

There is no change to workforce as a result of the change to dual purpose beds. Additional registered nurses have already been employed and an extra caregiver works mornings and afternoons.

The refurbished lounge now a bedroom that can accommodate two residents was verified as being appropriate to residents requiring hospital or rest home level of care.

Ngā huarahi ki te oranga | Pathways to wellbeing

Solemar has an admission package available prior to, or on entry to the service. The facility manager /clinical nurse manager and registered nurses are responsible for each stage of service provision. Ethnicity information of those enquiring after services has been added and data is collated and discussed.

Medication policies reflect legislative requirements and guidelines. The registered nurses and caregivers responsible for administration of medicines complete annual education and medication competencies. The electronic medicine charts reviewed meet prescribing requirements and are reviewed at least three-monthly by the general practitioner.

The registered nurses identify residents' food preferences and dietary requirements at admission. All food and baking is prepared and cooked on site in the kitchen. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines, and additional requirements/modified needs were being met. There are additional snacks available 24/7. The service has a current food control plan.

There are no changes required to medication administration and management or to food services as a result of the change from dementia beds to dual purpose beds.

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

The building holds a current warrant of fitness. All rooms (except one double room in the hospital area and a newly furbished double room) are single occupancy, spacious to provide personal cares and are personalised. Fixtures, fittings, and flooring are appropriate. Maintenance is completed on an ‘as required’ basis with plans for preventative maintenance. Residents freely mobilise within the communal areas, with safe access to the outdoors, seating, and shade. Fire drills occur six-monthly. The building is

secure at night to ensure the safety of residents and staff. There is always a staff member on duty and on outings with a current first aid certificate. Appropriate security checks and measures are completed by staff. Appropriate training, information, and equipment for responding to emergencies are provided. There is an emergency management plan in place and adequate civil defence supplies in the event of an emergency, including Covid-19. There are emergency supplies for at least three days.

There are no changes required to the environment as a result of the change from dementia beds to dual purpose beds apart from the shortfalls identified.

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

The service ensures the safety of residents and staff through a planned infection prevention and antimicrobial stewardship programme that is appropriate to the size and complexity of the service. The facility manager / clinical manager coordinates the programme.

A pandemic plan is in place. There are sufficient infection prevention resources, including personal protective equipment available and readily accessible to support this plan if it is activated.

Surveillance of health-care associated infections is undertaken, and results are shared with all staff. Follow-up action is taken as and when required. There were three outbreaks recorded since the last audit at the service and these were managed according to Ministry of Health guidelines.

The environment supports the prevention of transmission of infections. The environment, and facility were clean, warm, and welcoming. Waste and hazardous substances are well managed. There are safe and effective laundry services.

There are no changes required to the infection prevention and control programme as a result of the change from dementia beds to dual purpose beds.

Here taratahi | Restraint and seclusion

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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	11	0	1	2	0	0
Criteria	0	83	0	2	2	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)
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.

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 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 Moderate	Orewa Beach View Retirement Home & Hospital Limited trading as Solemar is certified to provide rest home, dementia, and hospital (geriatric) levels care for up to 30 residents. Currently, there are 15 dedicated dementia beds and 15 hospital level beds. On the day of audit there were a total of 24 residents (16 hospital and eight dementia level). All residents were under the age-related residential care (ARRC) contract. Two residents who were in the dementia unit have been reassessed by the Needs Assessment and Coordination Service (NASC) as requiring hospital level of care. The two residents recently reassessed are being supported with cares in the dementia care unit. There are weekly meetings with the funder discussing progress with the reconfiguration. The funder is aware of the two hospital level residents residing in the dementia unit. Notification to the funder confirming the two hospital residents remaining in the dementia unit was not able to be sighted on the day of audit. Currently there are 29 rooms with one room being able to accommodate a married couple. The owner/administrator has converted a large lounge into a bedroom that is also able to

		accommodate two residents noting that this would be either a shared room or able to accommodate a married couple. The room was verified as being able to accommodate two residents for either hospital or rest home level of care (dual purpose). This will now give Solemar a total of 30 rooms (with 32 residents if fully occupied). The existing double room is occupied by one resident and the newly converted double room has not yet been occupied. The service is managed by an experienced registered nurse who holds a dual role of facility manager and clinical manager (FM/CM). The FM/CM provides clinical governance for the facility and works closely with the owner/administrator. Both are identified as the governance group and the clinical governance structure in place is appropriate to the size and complexity of the service provision. The FM/CM has been in the current role since March 2022. Prior to this role, the FM/CM was employed in a management role for a large, aged care provider. The FM/CM has maintained at least eight hours annually of professional development activities related to managing a rest home and training related to cultural awareness, Te Tiriti o Waitangi, Te Whare Tapa Whā, and te ao Māori. The owner/director is the governing body for Solemar. The director and FM/CM interviewed were able to describe the company's business and quality goals. There is a 2024 business plan that outlines objectives for the period being implemented. The business plan includes a mission statement, scope, direction, goals, values, and operational objectives. The 2023 objectives have been reviewed and signed off when fully attained. Management reports reviewed showed adequate information to monitor performance is reported to governance (the owner/ director), including potential risks; contracts; human resource and staffing; growth and development; maintenance; quality management; and financial performance. The FM/CM and owner/director are in constant communication and meet face to face at least twice weekly. The owner/director attends staff meetings regularly. There is now evidence of meaningful Māori representation and input into organisational operational processes. On interview, the owner/director confirms that there is a family/whānau member who identifies as Māori (currently overseas) who is interested in

		supporting the organisation. There is a staff member who identifies as Māori who is able to provide support and is beginning to deliver training around Māori with the FM/CM also supporting the training. This has been put in place since the previous certification audit and the previous shortfall (2.1.9) has been met. The owner/administrator and the FM/CM described how residents have experienced improved health outcomes while in the service, and how this evidenced equity for tāngata whaikaha people with disabilities. The owner/administrator has completed training in Te Tiriti, health equity, and cultural safety. A transition plan is in place to change the existing dementia unit to dual purpose beds.
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. As service providers: We ensure our day-to-day operation is managed to deliver effective person-centred and whānau-centred services.	FA	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. The facility has already adjusted staffing levels to meet the changing needs of residents. There are two residents who were assessed previously as requiring dementia level of care. Both have had hospital admissions and both have now been assessed as hospital level of care. They continue to be supported in the dementia unit (link 2.1.6). Any resident who requires extra support including the use of a hoist or two people support have this provided by staff from the hospital side. There is a registered nurse on duty in the service 24/hours a day (a registered nurse on each shift) with the FM/CM also on duty on weekdays. Solemar has been affected by the nursing shortage and the FM/CM had been covering the morning shifts Two more nurses have been employed and these morning shifts are now able to be covered by a registered nurse. There are currently sufficient RNs on the roster to cover all shifts. Two other nurses have been interviewed and are in the process of signing contracts. Since the last audit, there has also been an increase of one caregiver on mornings and afternoon shift to support hospital level of care. The roster reviewed to reflect 31 dual purpose beds shows already sufficient staff to accommodate residents and a gradual process to increase staffing as required to meet acuity of residents. The transition plan documents the roll out.

		The FM/CM reported there were adequate staff to complete the work allocated to them. The FM/CM currently works in excess of 40 hours a week Monday to Saturday and is available on-call 24/7. The service continues to recruit RNs. Continuing education is planned on an annual basis, including mandatory training requirements. Evidence of regular education provided to staff was sighted in attendance records. The training topics on the in-service calendar included infection control /hand hygiene; outbreak management; moving and handling; safe food handling; pain identification and management; complaints; resident's Code of Rights; managing continence; cultural safety; Treaty of Waitangi; wound care; challenging behaviour; dementia care; and medication management. Related competencies are completed as required for registered nurses, such as interRAI, syringe driver competency, and controlled drug competency. Further training for registered nurses includes (but is not limited to), palliative care, pressure injury prevention, and management coordination. Care staff are supported to complete a New Zealand Qualification Authority (NZQA) education programme to meet the requirements of the provider's funding and service agreement. There are five caregivers who have achieved level 3 and above; one who has completed level 2 NZQA qualifications; and two are internationally qualified nurses going through their registration process. Of the eleven caregivers employed, four had completed dementia care training; the remaining are currently in training. Staff records reviewed demonstrated completion of the required training and competency assessments. The ethnic origin of each staff member is documented on their personnel records and used in line with health information standards. The FM/CM reported the Solemar model of care ensured that all residents are treated equitably. The provider has an environment that encourages collecting and sharing quality Māori health information. At the time of the audit, the service had staff and residents who identified as Māori. Staff wellness is encouraged through participation in health and wellbeing activities, including cultural days and shared meals at meetings. There are six registered nurses, including the FM/CM, with one being

		interRAI trained. The staff records sampled demonstrated completion of the required training and competency assessments.
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.	FA	Human resources management policies and processes reflect standard employment practices and relevant legislation. All new staff are police checked, and referees are contacted before an offer of employment occurs. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented. Each position has a job description. A total of five staff files were reviewed (two caregivers, two registered nurse and cook) were reviewed. Staff files included: reference checks; police checks; appraisals; competencies; individual training plans; professional qualifications; orientation; employment agreement; and position descriptions. Records were kept, confirming all regulated staff and contracted providers had proof of current membership with their regulatory bodies. This includes those related with the New Zealand (NZ) Nursing Council, the NZ Medical Council, pharmacy, and other allied health service providers. Each of the sampled personnel records contained evidence of the new staff member having completed an induction to work practices and standards and orientation to the environment, including management of emergencies. Staff performance is reviewed and discussed at regular intervals. Copies of current appraisals for staff were sighted. The ethnic origin of each staff member is documented on their personnel records. A process to evaluate this data is in place and this is reported to the owner/director at management meetings. Following incidents, the management team is available for any required debrief and discussion. There is no change required to staff records or to the onboarding process as part of this partial provisional audit.
Subsection 3.1: Entry and declining entry	FA	In cases where entry is declined, there is liaison between the FM/CM

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.		and the referral team. The prospective resident would be referred to the referrer. The FM/CM described reasons for declining entry would only occur if there were no beds available, or Solemar is unable to provide the service the prospective resident requires, after considering staffing and resident needs. There was a shortfall related to documentation of resident ethnicity and analysis of data at the previous certification audit. The service now documents the ethnicity of any potential resident on the enquiry form. The data is now recorded in the monthly reports showing how many prospective residents and family/whānau have viewed the facility, or admissions and declined referrals. Routine analysis shows entry and decline rates for any potential resident including Māori. The shortfall (3.1.5) has now been met with records sighted during the audit.
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.	FA	The FM/CM and registered nurse are responsible for conducting all assessments and for the development of care plans. The assessments and care plans reviewed are holistic and include all residents' needs. A shortfall (3.2.1) was identified at the previous certification audit around a lack of documented evidence that the residents and family/whānau are included in the development assessments and plans. There was evidence in one resident record reviewed on site that now had the assessment and plans signed by the resident and family/whānau confirming their involvement. The interRAI assessment for this resident now shows that a meeting with the resident and family/whānau had been held. The shortfall related to documentation to evidence resident and family/whānau input to assessments and care planning processes is now met.
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.	FA	Solemar has policies available for safe medicine management that meet legislative requirements. The registered nurse and medication competent caregivers who administer medications are assessed annually for competency. Education around safe medication administration is provided.

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.		The FM/CM interviewed could describe roles of staff in the administration of medication. Solemar uses robotic rolls for all regular and short course medications and blister packs for 'as required' medicines. All medications once delivered are checked by the registered nurses against the medication chart. Any discrepancies are fed back to the supplying pharmacy. Five medication records reviewed confirmed that reconciliation of medication is completed. Medications were appropriately stored in the medication trolley and medication room. The medication fridge and medication room temperatures are monitored daily, and the temperatures were within acceptable ranges. All eyedrops have been dated on opening. In the medication records reviewed, there is evidence of a three-monthly general practitioner review of all the residents' medication charts, and each drug chart has photo identification and allergy status identified. There is a policy in place for residents who request to self-administer medications. At the time of audit, there were no residents self-administering medications. Over-the-counter medication is considered during the prescribing process and these along with nutritional supplements, are documented on the medication chart. Standing orders are not used at Solemar. There are no vaccines kept on site. There is documented evidence in the clinical files that residents and family/whānau are updated about changes to their health. The FM/CM described how they work in partnership with residents who identify as Māori and their whānau to ensure they have appropriate support in place, advice is timely, easily accessed, and treatment is prioritised to achieve better health outcomes. There is no required change to medication administration and management as a result of the change from dementia to dual purpose beds or as a result of the additional bedroom.
Subsection 3.5: Nutrition to support wellbeing The people: Service providers meet my nutritional needs and	FA	The cook works full time Monday to Saturday and is supported by another trainee cook and a kitchen hand. All meals are prepared and cooked on site, with meals being plated and served from kitchen to

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 needs are met to promote and maintain their health and wellbeing.		the dining rooms in the dementia unit and by hotbox to the hospital dining area and residents' rooms as requested. Staff were observed wearing correct personal protective clothing in the kitchen and as they were serving meals. Staff were observed assisting residents with meals in the dining room and modified utensils, such as lip plates, are available for residents to maintain independence with meals. The FM/CM could describe a resident's food portion size and normal food and fluid intake and confirmed that RNs or staff report any changes in eating habits to a registered nurse and record this in progress notes. The kitchen was observed to be clean, well-organised, well equipped and with a current approved food control plan which expires 15 October 2025 (certificate sighted). The four-weekly seasonal menu has been reviewed by a dietitian April 2024. A resident dietary profile is developed for each resident on admission, and this is provided to the kitchen. The kitchen meets the needs of residents who require special diets. The FM/CM confirmed that the cooks work closely with the registered nurse and FM/CM with resident's dietary profiles and any allergies. Residents who require supplements for identified weight loss have them supplied. Kitchen staff are trained in safe food handling. Serving temperatures are taken on each meal. Chiller and freezer temperatures are taken daily and are within the accepted ranges. Cleaning schedules are maintained. All foods were date labelled in the pantry, chiller, and freezers. The FM/CM confirmed that one-to-one interaction of residents with staff and cooks in the dining room allows the opportunity for feedback on the meals and food services. The FM/CM interviewed understood basic Māori practices in line with tapu and noa. There is no required change to food services as a result of the change from dementia to dual purpose beds and with the addition of one more bedroom.
Subsection 4.1: The facility	PA	The current building warrant of fitness at Solemar expires 3 April

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.	Moderate	2025.The environment is inclusive of peoples' cultures and supports cultural practices. Maintenance requests are logged into a maintenance book and the facility manager arranges repair with chosen contractor. Essential contractors, such as plumbers and electricians, are available 24 hours a day, every day as required. There is an annual maintenance plan that includes electrical testing and tagging; resident's equipment checks; call bell checks; calibration of medical equipment; and monthly testing of hot water temperatures, which is managed by the FM/CM. Testing and tagging of electrical equipment was completed in February 2024. Checking and calibration of medical equipment, hoists and scales calibration was completed 27 March 2024. There are adequate storage areas for the hoist, wheelchairs, products, and other equipment. The service currently has two hoists for the 15 hospital wing and a third hoist is a newer model and is being trialled for a week prior to purchase. That will then be sufficient numbers of hoists for capacity (31 dual purpose beds). The service currently has chair scales with other equipment already purchased e.g. two more sphygmomanometers. There are already two thermometers. There is one oxygen concentrator and oxygen on site. There are sufficient supplies of linen and other equipment such as continence products already on site. The FM/CM stated that there are always sufficient supplies of continence products on site. The corridors have sufficient room to allow for safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. There is safe access to all communal areas and to the outside decked areas and gardens. The external courtyards and gardens have seating and shade. The service consists of 31 bedrooms (including the one verified during this audit to be able to cater for two residents). The facility is all on one level. It is currently split into two areas (hospital and secure dementia unit). The hospital consists of fifteen beds comprising of thirteen single rooms and two double rooms. At the time of audit the double room had single occupancy and the newly refurbished room is not yet occupied. All of the rooms had handbasins and a portion of them have shared toilets with a privacy lock. The newly converted lounge to a two-bed room has curtains

		around the beds and a small toilet in the room. The owner/administrator stated that this could be used my more mobile residents but not for residents using mobility equipment who would use a nearby communal toilet/shower area. The dementia unit currently consists of fifteen single rooms, some with handbasin and shared toilets which have a privacy lock system. The layout provides a secure environment. The walking paths are designed to encourage purposeful walking around the decked area. The secure external areas are safely maintained and were appropriate to the resident group and setting. There is room to store mobility aids, hoists, and wheelchairs. There are adequate numbers of accessible bathrooms and toilet facilities throughout the facility. The dementia unit is currently secure as there are still eight residents requiring dementia level of care. One set of doors from the dementia unit to the hospital area has a pin code lock and is able to be held open with a magnet for the door. The second door into the hospital area also has a pin code lock but is not able to be held open. The magnet anvils have been ordered. The secure unit will not be able to remain secure to accommodate the dual purpose beds. A visitor and staff toilet is also available at the facility. Residents can have personal items in their bedrooms. Bathrooms/showers have signs, handrails, and call bells. The rooms are well lit, ventilated, and heated. Flooring is carpet or vinyl and maintained in good condition. A variety of seating is provided to meet all resident's needs. Each area has an adequately sized lounge and dining room in which activities can take place. There are smaller quieter areas for residents and for family/whanau to spend time with residents. There are no required changes to spaces for communal activities when the dementia unit changes to dual purpose beds. The service has invited the Māori staff member and the Māori family/whānau to give comment on the change of the dementia unit to dual purpose rooms. The family/whanau member particularly has been in discussions with the FM/CM Currently in the dementia unit, there is a narrower hallway with six bedrooms on one side and the dining, lounge areas off on the other

		side. The doors have been taken off the lounge/dining rooms that lead into the hallway and this has allowed space for equipment to be able to turn into the bedrooms. A demonstration on the day confirmed that a hoist and fall out chair is able to be easily moved in and out of the bedrooms. Space in the dining/lounge areas allows for stretchers etc to be able to be turned into the rooms.
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.	PA Low	Emergency management policies that include a pandemic plan outline the specific emergency response and evacuation requirements, as well as the duties/responsibilities of staff in the event of an emergency. Emergency management procedures guide staff to complete a safe and timely evacuation of the facility in the case of an emergency. The fire evacuation plan scheme been approved by the New Zealand Fire Service 23 January 2014. The owner/administrator has not yet checked with Fire and Emergency Services to see if another fire evacuation plan is required with the change to dual purpose beds. A fire evacuation drill is repeated six-monthly, in accordance with the facility's building warrant of fitness; with the last fire drill having been completed in February 2024. There are emergency management plans to ensure health, civil defence and other emergencies are included. Civil defence supplies are in place. In the event of a power outage, the kitchen has gas cooking facilities. Emergency lighting (lasts for approximately three hours) is available to give staff time to organise emergency procedures. There are adequate supplies in the event of a civil defence emergency, including an equivalent of three litres of water per person, per day, for a three-day cover. The owner advised that the power company will provide a generator when power outage is extended. Information around emergency procedures is provided for residents and family/whānau in the admission information provided. The orientation programme for staff includes fire and security training. Staff interviewed confirmed their awareness of the emergency procedures. Registered nurse and caregivers files reviewed demonstrated evidence of completing first aid/CPR training. The rosters confirmed

		that there is at least one first aider on each shift. There are call bells in the residents' rooms, communal toilets/bathroom, and lounge/dining room areas. The new two - bedded room has a call bell for each bed. There is a display monitor at the nurses' station. Residents were observed to have their call bells in proximity to their current position. There are cameras in the hallways and communal areas. Entry into the dementia unit is by a code and the doors are set to automatically release in case of fire. The front door to the building is locked by staff at sunset and unlocked at sunrise. The building is secured after hours. Staff complete regular security checks at night. Visitors and contractors are instructed to sign in and complete visiting protocols. There are no changes to emergency systems or equipment required with the move to change dementia beds to dual purpose beds except for confirmation of the current fire evacuation plan.
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.	FA	The infection prevention (IP) and Antimicrobial Stewardship (AMS) policy was developed and aligns with the strategic document and approved by governance and linked to a quality improvement programme. All policies, procedures, and the pandemic plan have been updated to include Covid-19 guidelines and precautions, in line with current Ministry of Health recommendations. The FM/CM is the infection prevention and control coordinator, and reported they have full support from the owner/director regarding infection prevention matters. This includes time, resources, and training. Monthly staff meetings include discussions regarding any residents of concern, including any infections. The infection control coordinator has appropriate skills, knowledge, and qualifications for the role, having completed online infection prevention and control training as verified in training records sighted. Additional support and information are accessed from the infection control team at Health New Zealand- Waitemata, the community laboratory, and the GP, as required. There were three infection outbreaks reported since the previous audit, which were managed according to Ministry of Health

		guidelines and reported to the owner/director immediately.
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 FM/CM coordinates the implementation of the infection control programme. The infection control coordinator's role, responsibilities and reporting requirements are defined in the infection control coordinator's job description. The FM/CM has completed external education on infection prevention and control for clinical staff. The service has a clearly defined and documented infection control programme implemented that was developed with input from external infection control services. The infection control programme was approved by the owner/director and is linked to the quality improvement programme. The infection control programme is reviewed annually, and it was current. The infection control policies were developed by suitably qualified personnel and comply with relevant legislation and accepted best practice. The infection control policies reflect the requirements of the infection prevention and control standards and include appropriate referencing. The pandemic and infectious disease outbreak management plan in place is reviewed at regular intervals. Sufficient infection control resources, including personal protective equipment (PPE), were available on the days of the audit. Infection control resources were readily accessible to support the pandemic response plan if required. The infection control coordinator has input into other related clinical policies that impact on health care associated infection (HAI) risk and has access to shared clinical records and diagnostic results of residents. Staff have received education around infection control practices at orientation and through annual online education sessions. Additional staff education has been provided in response to the Covid-19 pandemic and at the time of outbreaks. Education with residents was on an individual basis as required. This included reminders about handwashing and advice about remaining in their room if they are unwell. This was confirmed in interviews with residents.

		The infection control coordinator consults with the owner/director on PPE requirements and procurement of the required equipment, devices, and consumables through approved suppliers and Health New Zealand- Waitemata. The owner/director stated that the infection control coordinator has been involved in the consultation process for the proposed changes to the dementia unit. Medical reusable devices and shared equipment are appropriately decontaminated or disinfected based on recommendation from the manufacturer and best practice guidelines. Single-use medical devices are not reused. There is a decontamination and disinfection policy to guide staff. Caregivers, and kitchen staff were observed following appropriate infection control practices, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers were readily available around the facility. The kitchen linen is washed separately, and towels used for the perineum are not used for the face. These are some of the culturally safe infection control practices observed, and thus acknowledge the spirit of Te Tiriti. The Māori health plan ensures staff are practicing in a culturally safe manner. The service has educational resources in te reo Māori. There is no required change to the infection prevention and control programme as a result of the change from dementia to dual purpose beds.
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	The antimicrobial stewardship (AMS) programme guides the use of antimicrobials and is appropriate for the size, scope, and complexity of the service. It was developed using evidence-based antimicrobial prescribing guidance and expertise. The AMS programme was approved by the owner/director. The policy in place aims to promote optimal management of antimicrobials to maximise the effectiveness of treatment and minimise potential for harm. Responsible use of antimicrobials is promoted. The GP has overall responsibility for antimicrobial prescribing. Monthly records of infections and prescribed treatment were maintained. The annual infection control

		and AMS review and the infection control audit include antibiotic usage, monitoring the quantity of antimicrobial prescribed, effectiveness, pathogens isolated, and any occurrence of adverse effects. There is no required change to the AMS programme as a result of the change from dementia to dual purpose beds
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	The infection surveillance programme is appropriate for the size and complexity of the service. Infection data is collected, monitored, and reviewed monthly. The data is collated, and action plans are implemented. The healthcare associated infections being monitored include infections of the urinary tract, skin, eyes, respiratory, and wounds. Surveillance tools are used to collect infection data and standardised surveillance definitions are used. Infection prevention audits were completed, including cleaning, laundry, and hand hygiene. Relevant corrective actions were implemented where required. Staff reported that they are informed of infection rates and regular audit outcomes at staff meetings. Records of monthly data sighted confirmed minimal numbers of infections, comparison with the previous month, reason for increase or decrease, and action advised. Any new infections are discussed at shift handovers for early interventions to be implemented. Surveillance of healthcare-associated infections now includes ethnicity data and the shortfall (5.4.3) identified at the previous certification audit has been addressed. There have not been any outbreaks since the previous audit. There is no required change to the infection prevention and control surveillance programme as a result of the change from dementia to dual purpose beds
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	FA	There are documented processes for the management of waste and hazardous substances. Domestic waste is removed as per local authority requirements. All chemicals were observed to be stored

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.		securely and safely. Material data safety sheets were displayed in the laundry. Cleaning products were in labelled bottles. The cleaning trolley was observed to be safely stored when not in use. A sufficient amount of PPE was available which includes masks, gloves, goggles, and aprons. There are dedicated housekeepers who are responsible for cleaning. Cleaning guidelines are provided. Cleaning equipment and supplies were stored safely in locked storerooms. Cleaning schedules are maintained for daily and periodic cleaning. The facility was observed to be clean throughout. The housekeepers have attended training appropriate to their roles. The FM/CM confirmed oversight of the facility testing and monitoring programme for the built environment. All resident clothing is laundered on site by caregivers. All linen is laundered by an external provider and delivered three times a week (Monday, Wednesday, and Friday) back to the facility. The on-site domestic laundry area has defined dirty and clean areas. Washing temperatures are monitored and maintained to meet safe hygiene requirements. Personal laundry is delivered back to residents in named baskets. Linen is delivered to cupboards in covered bags on trollies. There is enough space for linen storage. The linen cupboards were well stocked with good quality linen. Cleaning and laundry services are monitored through the internal auditing system. The washing machines and dryers are checked and serviced regularly. The infection control coordinator is involved in the implementation of the cleaning, laundry, and audits. There is no required change to waste management, laundry or cleaning as a result of the change from dementia to dual purpose beds.

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 2.1.6 Governance bodies shall ensure service providers deliver services that improve outcomes and achieve equity for tāngata whaikaha people with disabilities.	PA Moderate	There is a secure dementia unit currently with eight residents assessed as requiring dementia level of care. There are also two residents who were assessed as requiring dementia level of care but who have been reassessed by NASC and now require hospital level of care. Because they are familiar with their rooms and this partial provisional audit is to change the dementia beds to dual purpose use, the facility/clinical manager with support from the owner/administrator have agreed that they should stay in the dementia unit. The funder to date has not been notified of this.	The funder has not been notified of the decision made to keep two residents who were assessed as requiring dementia level of care but recently reassessed as requiring hospital level of care in the dementia unit.	Inform and discuss with the funder, the decision to keep two residents reassessed as requiring hospital level of care in the dementia unit. 30 days
Criterion 4.1.1 Buildings, plant, and	PA Low	The dementia unit is currently secure to ensure safety of residents requiring dementia	The secure unit till not be fit for purpose for residents requiring	Change the dementia unit to a non-secure

equipment shall be fit for purpose, and comply with legislation relevant to the health and disability service being provided. The environment is inclusive of peoples' cultures and supports cultural practices.		level of care. Two residents assessed as requiring hospital level of care are also being cared for in the secure dementia unit. Both residents were initially assessed as requiring dementia level of care and both are familiar with the environment. The two internal doors that lead from the dementia unit to the hospital wing are locked currently with a pin code. One set of doors is not able to stay open. There are currently eight residents still requiring a secure unit. The owner/administrator and FM/CM are currently working with family/whānau to relocate these residents. The facility manager reports that once all residents who are identified as requiring dementia level of care are transferred, then the unit will become unsecure.	hospital or rest home level of care.	unit once all residents requiring dementia care have been relocated to other facilities. Prior to occupancy days
Criterion 4.1.2 The physical environment, internal and external, shall be safe and accessible, minimise risk of harm, and promote safe mobility and independence.	PA Moderate	Bedrooms in the dementia unit are able to be locked with a coin used to unlock the bedroom doors. The FM/CM stated that the locks were only used to keep other residents out of rooms that were not theirs. The FM/CM stated that staff monitor residents and open the bedroom door if they wish to use their own room.	Bedrooms are locked when residents are in the lounge or dining areas.	Ensure residents can access their own rooms without having to wait for staff to open them. 30 days
Criterion 4.2.1 Where required by legislation, there shall be a Fire and Emergency New Zealand-approved evacuation plan.	PA Low	The fire evacuation scheme for the current configuration of a dementia unit and hospital wing has been approved by the New Zealand Fire Service 23 January 2014.	The owner/administrator has not yet checked with Fire and Emergency Services to see if another fire evacuation scheme is required with the change to dual purpose beds.	Ensure that the fire evacuation scheme meets the needs of the service in light of the change from the dementia unit to dual

				purpose beds. Prior to occupancy 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 audit.

No data to display

End of the report.