Ohope Healthcare Limited - Ohope Beach Care

Introduction

This report records the results of a 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 The DAA Group Limited, 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: Ohope Healthcare Limited

Premises audited: Ohope Beach Care

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

Dates of audit: Start date: 4 June 2025 End date: 5 June 2025

Proposed changes to current services (if any): Proposed sale of Ōhope Beach Care to Ōhope Healthcare Limited

Total beds occupied across all premises included in the audit on the first day of the audit: 34

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

Ōhope Beach Care provides age-related rest home and secure dementia care services for up to 36 residents. The facility is currently owned and operated by Ōhope Beach Care Limited. Residents and whānau were complimentary of the services being provided by Ōhope Beach Care, as was the general practitioner who services the facility.

This provisional audit was conducted to establish the prospective provider's preparedness to provide a health and disability service and the level of conformity of the exiting provider's service that is under offer to the prospective provider. It included a review of policies and procedures, review of residents' and staff files, observations, and interviews with the current owner, residents, whānau, the manager, staff, and a general practitioner.

An interview was also conducted with the prospective buyer. The proposed buyer is currently providing aged care services. There is a transition plan in place to manage the service which includes registered nurse support. The sale of the business is expected to occur on 1 July 2025.

Improvements made since the previous (surveillance) audit related to the collation of feedback from residents and whānau, governance learning in relation to cultural safety, the documentation of staff and resident ethnicity recording, and medication management. This audit identified that improvements are required in relation to external cultural engagement, the quality system and essential notification requirements, staffing and staff management, education and competency management, the environment and activity plans for the secure dementia unit, the availability of first aid qualified staff, infection control, and in the restraint process.

Ō tātou motika | Our rights

Ōhope Beach Care provided an environment that supported residents' rights. Staff demonstrated an understanding of residents' rights and obligations. There is a health plan in place that encapsulates care specifically directed at Māori. There were residents and staff in the service at the time of audit who identified as Māori. Māori residents entering the service confirmed that they had been provided with equitable and effective services based on Te Tiriti o Waitangi and the principles of mana motuhake (self-determination). Cultural assessment support is in place to inform the cultural care plan.

There were no residents who align with Pacific communities at Ōhope Beach Care at the time of the audit. Systems and processes were in place to enable Pacific people to be provided with services that recognised their worldviews in a culturally safe manner.

Residents and their whānau interviewed stated they were informed of their rights according to the Code of Health and Disability Services Consumers' Rights (the Code) and these were upheld. Residents said they felt safe from abuse, and they received services in a manner that respected their dignity, privacy, and independence. Observation and interviews with residents, whānau and staff during the audit demonstrated that Ōhope Beach Care provided services and support to people in a way that was inclusive and respected their identity and their experiences. Care plans accommodated the choices of residents and whānau.

There was evidence that residents and their whānau were kept well informed. They confirmed that they received information in an easy-to-understand format and felt listened to and included when making decisions about care and treatment. Open communication was practised. Interpreter services were provided as needed. Whānau and legal representatives were involved in decision-making that complied with the law. Advance directives were followed wherever possible.

Complaints processes were implemented. There has been one complaint received via the Office of the Health and Disability Commissioner since the previous (surveillance) audit.

Hunga mahi me te hanganga | Workforce and structure

The current owner of the service assumes accountability for delivering a high-quality service that is inclusive of, and sensitive to, the cultural needs of Māori. The current and prospective owners are experienced in governance and management, and they have completed education in cultural awareness, Te Tiriti o Waitangi and health equity.

Planning ensures the purpose, values, direction, scope and goals for the organisation are defined. Service performance was monitored and reviewed at planned intervals.

The quality and risk management systems were focused on improving service delivery and care and included the collection of quality improvement data. Staff participated in quality activities. Adverse events were documented, with corrective actions completed in most instances. The service was aware of the need for statutory and regulatory reporting.

Staff were suitably skilled and experienced and are orientated to the service. Caregiving staffing levels were sufficient to provide clinically and culturally appropriate care.

Residents' information was accurately recorded and securely stored and was not on public display or accessible to unauthorised people.

A transition plan was in place to transfer the facility to the prospective provider.

Ngā huarahi ki te oranga | Pathways to wellbeing

When residents were admitted to Ōhope Beach Care, a person-centred and whānau-centred approach was adopted. Relevant information was provided to the potential resident and their whānau. The service works in partnership with the residents and their

whānau to assess, plan and evaluate care. Care plans were individualised, based on comprehensive information, and accommodated any new problems that arose. Files reviewed demonstrated that care met the needs of residents and whānau and was evaluated on a regular and timely basis.

Residents were supported to participate in meaningful community and social activities suitable to their age and stage of life.

Medicines were safely managed and administered by staff who had been assessed as competent to do so.

The food service was managed safely and met the nutritional needs of the residents, with special cultural needs catered for.

Residents were referred or transferred to other health services as required.

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

The facility was clean and well maintained. There was a current building warrant of fitness. Electrical and biomedical equipment was assessed as required. External areas are available for resident use.

Staff were 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.

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

The current owner of Ōhope Beach Care ensured the safety of residents and staff by having a planned infection prevention and antimicrobial stewardship programme in place.

Staff, residents and whānau were familiar with the pandemic/infectious diseases response plan.

The service promoted responsible prescribing of antimicrobials. Infection surveillance was undertaken, with follow-up action taken as required.

Waste and hazardous substances were well managed. There were safe and effective cleaning services, and laundry services were effective.

Here taratahi | Restraint and seclusion

The service has a philosophy and practice of no restraint. This is supported by the current owner and the prospective owner of the facility.

While there were no residents using restraints at the time of audit, there are policies and procedures in place to guide the restraint process should they be required. Staff interviewed 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	17	0	2	8	0	0
Criteria	0	147	0	5	16	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 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	Ōhope Beach Care (Ōhope) has embedded a Māori model of health into its care planning processes. The principles of Te Tiriti o Waitangi are actively acknowledged when providing support to Māori residents and their whānau. The organisation's Māori Health Plan reflected a commitment to Te Tiriti o Waitangi and providing inclusive person-/whānau-centred support. Māori residents and their whānau interviewed reported that their mana was protected, that they were treated with dignity and respect, and that staff provided culturally safe care. At the previous (surveillance) audit, the service had access to a kaumatua, but this is no longer in place. At the time of audit, there were staff employed who identified as Māori and they have links to local iwi or other Māori communities in the area. There are staff in the service who are te reo Māori speakers. Staff ethnicity data was documented on recruitment and trended. Both the current owner and the prospective owner understand their responsibilities to Māori in the service.

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 residents who aligned with Pacific communities in the service, a staff member (who identifies with a Pacific community) confirmed that there was support in place to make sure residents would have their cultural and spiritual needs and beliefs identified, recorded and considered. One staff member who identified as from a Pacific community confirmed knowledge of local Pacific communities and organisations that are available to advise and provide information. The service has detailed policies on a range of Pacific cultures that can also guide staff. Both the current owner and the prospective owner understand their responsibilities to residents who align with Pacific communities who may be housed in the service.
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	Staff interviewed at Ōhope understood the requirements of the Code of Health and Disability Services Consumers' Rights (the Code) and were observed supporting residents in accordance with their wishes. Residents and whānau interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) and were provided with opportunities to discuss and clarify their rights. Posters on the Code were displayed in the front entranceway, and brochures on the Code and the Advocacy Service were available and accessible. The prospective provider is already a provider of aged care and medical services and understood the consumer rights it will be expected to adhere to.
Subsection 1.4: I am treated with respect	PA Low	The service supported residents in a way that was inclusive and

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. As service providers: We provide services and support to people in a way that is inclusive and respects their identity and their experiences.		respected their identity and experiences. Residents and whānau, including people with disabilities, confirmed that they received services in a manner that had regard for their dignity, gender, privacy, sexual orientation, spirituality and choices. Staff were observed to maintain privacy throughout the audit. All residents had a private room. Te reo Māori and tikanga Māori were promoted within the service. Staff members communicate in te reo Māori with residents who also identified as Māori. No evidence was found to indicate that staff had participated in training on Te Tiriti o Waitangi in the past two years (refer criteria 1.4.5 and 2.3.4); however, interviews and observation verified staff understood the principles and how to apply these in their daily work. The needs of tāngata whaikaha were responded to, including their participation in te ao Māori. The current and prospective provider understood their equity responsibilities when caring for tāngata whaikaha in the facility.
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	Staff understood the service's policy on abuse and neglect, including what to do should there be any signs of such behaviour. There were no examples of discrimination, coercion or harassment identified during the audit through staff and/or resident or whānau interviews, or in documentation reviewed. Residents' property was labelled on admission, and valuables photographed. Residents and whanau reported that their property was respected, and their finances protected. Staff maintained professional boundaries. Staff interviewed felt comfortable in raising any concerns in relation to institutional and systemic racism, and that any concerns would be acted upon. A strengths-based and holistic model of care was evident in the care being provided.

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.	FA	Residents and whānau reported that communication was open and effective, and they felt listened to. Information was provided in an easy-to-understand format. Changes to residents' health status were communicated to whānau in a timely manner. Where other agencies participated in care, communication had occurred. Examples of open communication was evident following adverse events, changes in residents' care needs, and visits by the general practitioner (GP). Staff knew how to access interpreter services, if required. The previous (surveillance) audit identified that an improvement was required around processes for resident and whānau feedback, as information from resident surveys/feedback was not being collated and reported on; this has been addressed. Feedback from surveys, residents' meetings and concerns were collated, addressed, and responded to, as evidenced by meeting minutes, newsletters, interviews, and through documentation.
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	Residents and/or their legal representative were provided with the information necessary to make informed decisions. They felt empowered to actively participate in decision-making. With the consent of the resident (where applicable), whānau were included in decision-making. Nursing and care staff interviewed understood the principles and practice of informed consent, supported by policies in accordance with the Code and in line with tikanga guidelines. Advance care planning, establishing, and documenting of Enduring Power of Attorney (EPOA) requirements and processes for residents unable to consent were documented, as relevant, in the resident's record. Files reviewed of residents in the secure dementia care unit evidenced an activated EPOA was in place.
Subsection 1.8: I have the right to complain	FA	Complaints policies and processes meet the requirements of the

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.		Code. Complaints management was identified as a concern in the previous (surveillance) audit; this has been addressed. Although no complaints have been received by the service, a fair, transparent and equitable system is now in place for receiving and resolving complaints, which contributes to continuous improvements. Evidence was observed of significant engagement by the service manager with both residents and their whānau. Residents and whānau interviewed reported that any minor concerns were promptly addressed by the manager, that they understood their right to lodge a complaint, and that they were aware of the process for doing so. The service assured the process works equitably for Māori by using hui, appropriate tikanga, and/or the use of te reo Māori, as applicable. One complaint has been received from the Office of the Health and Disability Commissioner (HDC) in relation to the care and the physical environment of a resident (no longer in the service). This was received in November 2024 and was responded to in January 2025 (following an extension permitted by the HDC); the complaint remains open. There have been no known complaints received from any other external agency.
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.	FA	Ōhope has been privately owned and operated for approximately 15 years and assumes accountability for delivering a high-quality service to the resident communities served. Governance overview was identified as a concern in the previous (surveillance) audit; since that time, the current owner of the service has completed training in Te Tiriti o Waitangi, health equity and cultural safety and is more familiar with the governance obligations under the Ngā Paerewa Standard addressing the concerns raised. The prospective owner of the service is an experienced medical practitioner who is also experienced in management, familiar with the governance obligations under the Ngā Paerewa Standard, and has completed training in Te Tiriti o Waitangi, health equity and cultural safety. The

		prospective owner currently runs a medical practice and an aged-care facility in the Auckland area. Both the current and prospective owner of the facility are in the process of advising Health New Zealand – Te Whatu Ora (Te Whatu Ora) of the prospective sale. The leadership structure, including for clinical governance, is appropriate to the size and complexity of the organisation and there is a suitably qualified person managing the service. The facility manager (FM) is a registered nurse (RN) and clinical lead, who is supported by another senior RN with a further RN who is orientating to the service. The FM and senior RN are both, however, on casual rather than permanent contracts (refer criterion 2.3.1). The purpose, values, direction, scope and goals are defined, and monitoring and reviewing of performance occurs through regular reporting at planned intervals. A focus on identifying barriers to access, improving outcomes, and achieving equity for Māori, people aligned with Pacific communities, and tāngata whaikaha was evident in plans and monitoring documentation reviewed. A commitment to the quality and risk management system was evident. The current owner interviewed felt well informed on progress and risks and attends quality meetings at the facility. The prospective provider does not intend to make any changes in performance reporting in the first instance, except for the change from the current owner to them. Compliance with legislative, contractual and regulatory requirements is overseen by the leadership team, which consists of the current owner, the FM and the senior RN, with external advice sought as required. The service has implemented a resident management system that includes a comprehensive set of policies and procedures. These policies and procedures, provided by an external provider, reflected substantial input from Māori. The facility has capacity for up to 36 residents, comprising 11 rest home and 25 secure dementia care beds. On the days of audit, 34 beds were occupied by 10 rest home level care residents, one of whom was receiving services under a long-term support – chronic health conditions contract (LTS-CHC), and 24 residents in the secure dementia care unit. Services are provided under Age-

		Related Residential Care (ARRC) agreements with Te Whatu Ora.
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 Moderate	The organisation has an established quality and risk management system that aligns with the principles of continuous quality improvement. The prospective owner of the facility has no plans to change current systems and will continue with the use of the current quality and risk management system, which is maintained and regularly updated by an external provider, and which is actively implemented in the service. The quality and risk management system includes management of incidents and complaints, audit activities, a regular resident satisfaction survey, monitoring of outcomes, policies and procedures, clinical incidents including infections and adverse events, and essential notifications relevant for the service. Most of these are managed well; however, some areas are not fully managed and these need to be addressed (refer criteria 2.2.2 and 2.2.6). Policies reviewed covered all necessary aspects of the service and of contractual requirements and were current. Residents and whānau contribute to quality improvement through regular meetings and participation in a resident satisfaction survey. Feedback received through both channels has been overwhelmingly positive, indicating a high level of satisfaction with the services provided at Ōhope. Staff also contribute to quality improvement through regular meetings; evidence was sighted in meeting minutes that staff have input into the meeting, and this was confirmed by staff at interview. Critical analysis of practices and systems, using ethnicity data, identifies possible inequities and the service works to address these. Delivering high-quality care to Māori residents was supported through Māori health plans, tikanga policies, and access to Māori (te reo Māori speaking) staff and cultural support. Staff documented adverse and near-miss events in line with the National Adverse Events Policy. A sample of incident/accident forms reviewed showed that, with the exception of neurological observation (refer criterion 2.2.2), these were fully completed, incidents were

		investigated, action plans developed, and actions followed up in a timely manner. The prospective provider has a transition plan in place and, beyond contract negotiations with staff to move employment to Ōhope Healthcare Limited, does not intend to change any of the processes already in place. The prospective provider has the resources, through knowledge of the industry and an experienced manager employed at another facility, to assist with any corrective actions arising from this audit. Discussion with the current owner of the facility and the FM showed that, while they were aware of the need for statutory and regulatory notifications, they did not fully understand essential notification reporting requirements (refer criterion 2.2.6). The prospective owner described essential notifications when interviewed.
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.	PA Moderate	There is a documented and implemented process for determining staffing levels to provide culturally and clinically safe care, 24 hours a day, seven days a week (24/7). The facility adjusted staffing levels to meet the changing needs of residents and there were te reo Māori speaking staff available to support Māori in the service. Ethnicity of staff was documented, correcting a finding from the previous (surveillance) audit. A multidisciplinary team (MDT) approach ensured all aspects of service delivery were met. Those providing care reported there were adequate staff to complete the work allocated to them. Residents and whānau interviewed supported this. There was sufficient registered nurse (RN) cover for the facility. There were first aid certified staff in the facility, but there was not always one on duty on the rosters sighted (refer criterion 4.2.4). At the time of audit, the staff currently employed by the service had not been approached to continue their employment with the new provider (refer criterion 2.3.1) and not all staff were aware of the potential sale. The current owner and FM for the service were confident that most staff will move to the new provider.

		An employment process was in place; however, on the staff records sighted, there were a few (three from six files examined) who did not have job descriptions in place to specify the requirements for the position and key performance indicators (KPIs) to assess performance. This included the FM, who was also responsible for infection prevention and control and restraint (refer criteria 2.4.2, 5.2.1 and 6.1.3). Staff were interviewed prior to employment; qualifications were checked and candidates police-vetted; no reference checks were sighted on the records examined (refer criterion 2.4.1). There were processes in place for training and support in place for residents and whānau depending on need. Collecting and sharing of high-quality Māori health information is through policies and procedures, health plans specific to Māori and people from Pacific communities, and through care planning. While staff have not had specific education on health equity (a finding in the previous (surveillance) audit), Māori staff and staff aligning with a Pacific community supported health equity in the facility along with engagement with residents and their whānau. Māori residents and whānau in the service confirmed that services are rendered equitably and in a way that met their cultural needs; tāngata whaikaha in the service confirmed services are provided in an equitable fashion (there were no residents from Pacific communities in the service during the audit). While some education for staff had been delivered, continuing education was insufficient and not planned. This was a finding in the previous (surveillance) audit, and it has not been addressed. A new system for managing education has been purchased but this is not yet implemented (refer criterion 2.3.4). In addition to this, the FM, who works as the infection control nurse and restraint coordinator, had not completed any education relevant to the role (refer criterion 6.1.3). With the exception of medication competency, annual competency assessments had not been completed (refer criterion 2.3.3), except during the orientation of new staff. Not all care staff who work in the secure dementia care area of the facility have commenced or completed a New Zealand Qualification Authority (NZQA) education programme to meet the requirements

		of the provider's agreement with the Te Whatu Ora (refer criterion 2.3.1). This was a finding in the previous (surveillance) audit that has not been addressed. Staff reported feeling well supported and safe in the workplace and reported a positive work environment.
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 Moderate	Human resources management policies and processes are based on good employment practice and relevant legislation, but these are not fully implemented in the service (refer criterion 2.4.1). The prospective provider is already an owner of a medical and aged-care business and is aware of the requirements for employing staff. Professional qualifications and registration (where applicable) had been validated prior to employment, and these are being checked annually. Staff reported that the induction and orientation programme prepared them well for the role, and evidence of completed orientation was seen in files reviewed. Orientation included knowledge of the new electronic resident management system (which included facility policy documents) and competencies required for the role (refer criterion 2.3.3). Annual review of performance had not taken place in the staff records reviewed (refer criterion 2.4.5). Staff information, including ethnicity data, was accurately recorded, held confidentially, and used in line with the Health Information Standards Organisation (HISO) requirements. Opportunities to be involved in a debrief and discussions following any serious incidents or challenging situations were provided, as confirmed by staff interviewed.
Subsection 2.5: Information The people: Service providers manage my information sensitively and in accordance with my wishes.	FA	All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current, integrated and legible and met current documentation standards. Resident information was integrated into

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.		an electronic resident management and medication management system and accessible for all those who need it. Records are individually username and password protected. Files are held securely for the required period before being destroyed. No personal or private resident information was on public display during the audit. The prospective employer was aware of the need to maintain privacy and confidentiality in the service, for residents and staff. The 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.	FA	Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) agency, and for the secure dementia care unit, a specialist's authorisation that care in a secure unit is required. Whānau interviewed were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed of residents in the secure dementia care unit evidenced an activated EPOA was in place. Where a prospective resident was declined entry, there were processes for communicating the decision. Related data is documented and analysed, including decline rates for Māori. Ōhope had relationships with Māori organisations through its staff's connections to local marae and community organisations. Residents and whānau expressed satisfaction with the admission process and the delivery of care. They confirmed they were treated with dignity and respect. The organisation also works in partnership with whānau to enable Māori residents to visit and access support from their local maraes.
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.	FA	The multidisciplinary team at Ōhope works in partnership with the resident and whānau to support wellbeing. A care plan, based on one of the provider's models of care, was developed by suitably qualified staff following a comprehensive assessment, including consideration of the person's lived experience, cultural needs,

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.		values, and beliefs, and taking into consideration wider service integration, where required. Early warning signs and risks, with a focus on prevention or escalation for appropriate interventions, were recorded. Assessment was based on a range of clinical assessments and included resident and whānau input (as applicable). Timeframes for the initial assessment, GP assessment, initial care plan, interRAI assessments, long-term care plans and review timeframes met contractual requirements. Staff understood and supported Māori and whānau to identify their own pae ora outcomes in their care plan. A review was undertaken of six residents' files, three from residents requiring care in the secure dementia care unit, two from residents requiring rest home care, and a resident receiving rest home care under an LTS-CHC contract. Care plans reviewed addressed all the residents' required needs. Changes in medications were documented on short-term care plans, with the required monitoring in place to assess the impact of the new regime. Residents with behaviours that challenge were supported by specialist input from Te Whatu Ora Mental Health Services for Older People (MHSOP). Three residents who experienced recent unwitnessed falls had an initial neurological assessment completed. However, ongoing neurological monitoring was not consistently maintained in accordance with the required guidelines (refer criterion 2.2.2). Within the secure dementia care unit, none of the three residents reviewed had a 24-hour care plan that incorporated their prior lifestyle patterns. This lack of individualised planning does not meet requirements and may affect the provision of person-centred care (refer criterion 3.3.1). This was verified by sampling residents' records, and from interviews of clinical staff, people receiving services and whānau. Management of any specific medical conditions was well documented with evidence of systematic monitoring and regular evaluation of responses to planned care, including the use of a range of outcome measures. Where progress was different to that expected, changes were made to the care plan in collaboration with the resident and/or whānau. Residents and whānau confirmed

		active involvement in the process. Tāngata whaikaha participated in service development through resident meetings, satisfaction surveys, and ongoing discussion. Examples of choices and control over service delivery were discussed with staff/tāngata whaikaha/whānau. Tāngata whaikaha/whānau can independently access information.
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 Low	The activities programme at Ōhope supported residents to maintain and develop their interests and was suitable for their age and stage of life. The programme was provided by a diversional therapist (DT) and two activities assistants (AA) seven days per week. Activity assessments were completed on admission to identify each resident’s interests, strengths and skills. The activities programme was developed and implemented based on these individual interests. Each resident had a documented activity plan that outlines their personal goals and areas of interest. During the audit, the activities programme observed was diverse, offering a variety of options to support engagement and meaningful participation for residents. Activities were provided for residents in both the rest home and the secure dementia care unit. While each area has its own tailored programme, joint sessions were occasionally held, particularly for music-related activities such as singing. These events were inclusive and encouraged social interaction and community engagement. A recent suggestion to introduce more enriching activities has been actioned, with enhancements made to the programme. Notably, residents and staff now participate by playing musical instruments while others join in singing, contributing to a vibrant and engaging atmosphere in the facility. Individual and group activities reflected residents’ goals and interests and ordinary patterns of life and included normal community activities. Opportunities for Māori and whānau to participate in te ao Māori were facilitated, through language, song, and celebrations of Matariki, Waitangi Day and Māori Language Week, and visits to marae and communities outside of the service. Younger residents at Ōhope are supported to engage in meaningful activities and are given opportunities to participate in community events that align

		with their personal interests. Feedback on the activities programme was provided through feedback at the time, resident meeting minutes, resident surveys, and observations. Documentation, observation and interviews confirmed the programme met the needs of residents. A requirement for residents in the secure dementia care unit to have a 24-hour activities plan that reflects their previous lifestyle patterns was not evidenced during the audit. This is an area requiring attention to promote person-centred care (refer criterion 3.3.1). A facility van was available for outings, which occur each week. The 2012, 12-seater van was noted to have an up-to-date registration and a warrant of fitness that expires in July 2025.
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 policy was current and in line with the Medicines Care Guide for Residential Aged Care. A safe system for medicine management (using an electronic system) was observed on the day of audit. All staff who administer medicines had been assessed as competent to perform the function they managed. Medication reconciliation occurs. All medications sighted were within current use-by dates. Medicines were stored safely, including controlled drugs. The required stock checks had been completed. Medicines stored were within the recommended temperature range. Prescribing practices meet requirements. The previous (surveillance) audit found that not all medication records had residents' medication allergies and sensitivities recorded; this has been addressed. Medicine-related allergies or sensitivities were recorded on the records sighted, and any adverse events responded to appropriately. Over-the-counter medication and supplements are considered by the prescriber as part of the person's medication. The required three-monthly GP review was consistently recorded on the medicine chart. Standing orders were not used at Ōhope. A previous audit identified that when (as required) pro re nata

		(PRN) medication was administered, the effectiveness of this was not consistently documented. This has been addressed and all PRN medication administered had the effectiveness of its use documented in the residents' records post-administration. There were no residents self-administering medications at Ōhope at the time of audit. Processes were in place for self-administration of medication to be facilitated and managed safely if required. Residents, including Māori residents and their whānau, are supported to understand their medications.
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 needs are met to promote and maintain their health and wellbeing.	FA	The food service at Ōhope was in line with recognised nutritional guidelines for people using the services. The menu had been reviewed by a qualified dietitian on 3 May 2025. Recommendations made at that time have been implemented. All aspects of food management complied with current legislation and guidelines. The service operated with an approved food control plan and registration, verified by Whakatane District Council. The plan expires on 18 September 2025. Each resident had a nutritional assessment on admission to the facility. Personal food preferences, any special diets and modified texture requirements were accommodated in the daily meal plan. Māori and their whānau had menu options that are culturally specific to te ao Māori. Food and fluids were available in the secure dementia care area of the service 24/7. Evidence of resident satisfaction with meals was verified by resident and whānau interviews, satisfaction surveys and resident meeting minutes. Residents were given sufficient time to eat their meals in an unhurried fashion and those requiring assistance had this provided with dignity.
Subsection 3.6: Transition, transfer, and discharge The people: I work together with my service provider so they know what matters to me, and we can decide what best supports my	FA	If a resident required transfer or discharge from Ōhope, the process was planned and managed safely with coordination between services and in collaboration with the resident and whānau. Risks

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.		and current support needs were identified and managed. Options to access other health and disability services and social/cultural supports were discussed, where appropriate. Whānau reported being kept well informed during the transfer of their relative. On the day of audit, a resident was being transferred to another facility; the transfer included the farewelling of the resident with song and music provided by other residents and staff.
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.	PA Moderate	The building had a current warrant of fitness with an expiry date of 11 October 2024. There have been no changes to the building structure or footprint since the previous (surveillance) audit. The current and prospective owner were aware that consultation or co-design with Māori needs to occurs when a new building was in the design process. The building and grounds are in reasonable repair. Plant and equipment were well maintained, and new equipment was purchased as required to promote resident independence and mobility. Records sighted confirmed annual checking, tagging and testing, and calibration of electrical devices and medical equipment. Testing and tagging of all ‘plug-in’ electrical equipment and biomedical checks and calibration occurred in January 2025. Hot water temperature monitoring was occurring, as confirmed by the records sighted. The internal environment was inclusive of residents’ cultures. For example, signage throughout the home was in te reo Māori and English, and the internal décor reflected all cultures. There are adequate numbers of accessible bathroom and toilet facilities throughout the facility, including for visitors and staff. Each resident’s bedroom was personalised, warm and well-ventilated by large opening windows and individual heaters. 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 The environment in the rest home was comfortable and accessible,

		promoting independence and safe mobility and minimising risk of harm. Residents in the rest home were observed to be independently accessing the gardens, decks and external areas. There was sufficient safe and suitable seating, handrails, flat walking surfaces and shade options provided. Smaller leisure spaces were available for residents to use. There are a number of environmental issues to be addressed in the dementia care unit, particularly the safety and security of residents when accessing external garden areas (refer criterion 4.1.2). The lounge area in the secure dementia area does not support resident comfort, with little comfortable seating available for the number of residents (refer criterion 4.1.3). A smaller leisure area in the unit was not sighted being used on the day of audit and the manager and staff confirmed it was not used by residents; the area did not have good light, and the heating was not on in the area (the day was cold). Both the current and prospective owners were aware of the gardens' security risks. Added to this, the laundry area requires attention (refer criteria 4.1.2). The area is small, unkempt, and the equipment needed for staff to manage effective infection control when sluicing soiled linen was out of reach. Residents and whānau interviewed, however, reported that they were happy with the environment, including heating and ventilation, natural light, privacy and maintenance.
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 Moderate	Disaster and civil defence plans and policies direct the facility in its preparation for disasters and described the procedures to be followed. Staff have received relevant information and training and have appropriate equipment to respond to emergency and security situations. Staff interviewed knew what to do in an emergency. One of the fire evacuation routes is through a bedroom area in the secure dementia area. The external door is locked and requires a key to open it; however, regardless of the locked door, the fire evacuation plan was approved by Fire and Emergency New Zealand (FENZ) in April 2023 following a visit to the site. Six-

		monthly fire evacuation drills had been occurring. The most recent drill occurred on 6 December 2024; a further fire evacuation was scheduled for the week of audit. Firefighting equipment checks are carried out by a contracted fire security service. An adequate amount of food, medical, and safety supplies for up to 36 residents plus staff was being stored on site. This meets the National Emergency Management Agency 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 gas (LPG) cooker, torches, and additional blankets for warmth. Supplies are, however, not being checked on a regular schedule and there is insufficient water stored on site (refer criterion 4.2.7). There are 20 first aid certified staff working in the facility. On the rosters sighted, morning and afternoon shifts were covered but some night shifts were not covered (refer criterion 4.2.4). On-call nursing and medical cover is provided by the manager (who lives near to the facility) and the GP (remote). Call bells alert staff to residents requiring assistance. The call bell system was witnessed to be functional during the audit, and residents and whānau reported that staff responded to these in a timely way. Doors and windows were locked at dusk. All visitors were required to sign in to the facility and sign out when leaving. Residents and whānau were familiarised with emergency and security arrangements on admission and subsequently as and when required; familiarity was confirmed by residents and whānau interviewed.
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	FA	The infection prevention (IP) and antimicrobial stewardship (AMS) programmes are appropriate to the size and complexity of the service. The programmes have been developed by an infection control specialist provider and endorsed and approved by the current owner. The infection prevention programme contributes to the safety of residents and staff and infection levels are low. The prospective owner of the facility is aware of their governance

in national and regional IP and AMS programmes and respond to relevant issues of national and regional concern.		responsibilities for IP and AMS. Infection prevention policies and procedures provide a structured, stepwise approach to the management of infection events and support a multidisciplinary response. The infection control nurse (ICN), who also serves as the FM and clinical lead, confirmed that these policies and procedures would guide the management of any infection event. The IP and AMS programmes are integrated into the facility's quality system. They are reviewed as part of regular quality meetings, which are attended by the current facility owner; however, annual reporting was not occurring (refer criterion 5.2.2). Additional expertise and advice were accessed through a defined process, typically involving the facility's GP, Te Whatu Ora, or Regional Public Health.
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.	PA Moderate	The FM, who is also the clinical lead, has assumed responsibility for implementing the infection prevention (IP) and AMS programmes, with reporting lines to the current owner of the facility. The FM has no job description for the IP role and has had no recent training in IP or AMS (refer criteria 2.4.2 and 5.2.1). The FM has, however, confirmed the ability to access the necessary resources and support if required. Their advice has been sought when making decisions around procurement relevant to care delivery, facility changes, and policies. The infection prevention and control (IPC) policies provided by the external advisory company reflected the requirements of the standard and are based on current accepted good practice. The programme contained documentation and references to verify that it had been developed in partnership with Māori and reflected Te Tiriti o Waitangi. Cultural advice is accessed where appropriate. Staff were familiar with policies and were, with the exception of laundry staff, observed to follow these correctly (refer criterion 5.5.4). Staff, however, had had no IP and AMS training at defined intervals by a person trained in IP and AMS. This was an area identified as requiring attention at the last audit and remains in

		place (refer criterion 2.3.4 and 5.2.6). Residents and their whānau were educated about infection prevention in a manner that meets their needs. Educational resources were available in te reo Māori. A pandemic/infectious diseases response plan is documented and has been regularly assessed. There were sufficient resources and personal protective equipment (PPE) available. Staff were familiar with policies for decontamination of reusable medical devices and there was evidence of these being appropriately decontaminated and reprocessed. Audits to maintain good practice had not been completed at regular intervals (refer criterion 2.2.2). Single-use medical devices were not reused.
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	Responsible use of antimicrobials was promoted. The AMS programme is appropriate for the size and complexity of the service, is supported by policies and procedures, and endorsed by the current owner of the facility. The GP interviewed confirmed antibiotic prescribing occurred as per best practice guidelines; reports were sighted that included the number and type of infections, with an analysis that included the antibiotic course prescribed, its outcome and any adverse effects. The overall effectiveness of the AMS programme had not been evaluated on an annual basis through monitoring antimicrobial use and identifying areas for improvement (refer criterion 5.2.2).
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	FA	Surveillance of health care-associated infections (HAIs) is appropriate to that recommended for the type of services offered and is in line with risks and priorities defined in the infection control programme. Monthly surveillance data, using standardised surveillance definitions, was collated and analysed to identify any trends, possible causative factors and required actions. Surveillance included ethnicity data. Results of the surveillance programme were shared with staff and the current owner, and where necessary, recommendations for improvement were identified. Communication between service providers, and those residents

focus.		experiencing a health care-associated infection (HAI), was culturally safe.
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 clean and hygienic environment supports prevention of infection and mitigation of transmission of antimicrobial-resistant organisms, with the exception of the laundry area (refer criterion 4.1.2). There is an absence of personnel with IP expertise to have oversight of the environmental testing and monitoring programme (refer criterion 5.2.7). Staff followed documented policies and processes that ensured protection from harm for the management of waste, hazardous substances and infectious material (with the exception of laundry staff – refer criterion 5.5.4). Cleaning and laundry processes were monitored visually for effectiveness, but audits were not completed (refer criterion 2.2.2). Schedules for cleaning and laundering processes were documented and signed off when completed. Staff involved in cleaning and laundry activities have not completed relevant training and laundry personnel were observed to not perform their duties safely (refer criterion 5.5.4). Chemicals and equipment involved in cleaning and laundry processes were stored safely and securely. Residents and whānau reported that their laundry was managed well, and the facility kept clean and tidy.
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.	PA Moderate	Ōhope has a philosophy and practice of no restraint, which is endorsed by the current owner of the service and understood by the prospective owner. There are policies and procedures in place that meet the requirements of this standard and provide guidance on the safe use of restraints if these are ever required. The residents' GP, EPOA or whānau would be involved in decision-making should restraint be considered. No restraint has been used for over 12 years. Interviews, documents reviewed, visual inspection and other observations during the days of audit confirmed there were no residents using restraint. Alternatives to restraint interventions being

		used are de-escalation, provision of a low stimulus environment, low beds, and sensor mats linked to the call bell system. There were processes to follow for reporting restraint if this is required and the current owner of the facility attended quality meetings where restraint was reported. The FM, who is the clinical lead, is nominated as the restraint coordinator; however, the FM has no job description for the role and has had no specialist education for the role over the last two years (refer criterion 6.1.3). The FM is committed to maintaining a restraint-free environment. Staff have not been trained in the least restrictive practice, safe restraint practice, alternative cultural-specific interventions, and de-escalation techniques in 2024 or 2025 (refer criterion 6.1.6) and, given there is no annual plan in place, restraint is not part of education planning. This was a finding at the previous (surveillance) audit and a corrective action required by Te Whatu Ora following a complaint made to the HDC, and this has not been addressed. Given restraint is not in use, subsections 6.2 and 6.3 have not been audited.

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 1.4.5 Services shall ensure health care and support workers receive Te Tiriti o Waitangi training and that this is reflected in day-to-day service delivery.	PA Low	No evidence was found to indicate that staff had participated in training on Te Tiriti o Waitangi in the past two years. Interviews with residents, whānau and staff, along with observation during the audit, verified staff understood and applied the principles in their daily work. Residents and whānau in the service reported feeling culturally safe.	Staff had not participated in training on Te Tiriti o Waitangi in the past two years.	Provide evidence that staff have participated in training on Te Tiriti o Waitangi. 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	PA Moderate	A review of incident and accident forms confirmed that they were generally completed in full, incidents were investigated appropriately, and action plans were developed and followed up in a timely manner. However, an	Neurological observations are not being conducted following an unwitnessed fall or a witnessed 'blow' to the head, as required by the service's policy and in accordance with best practice guidelines.	Provide evidence that neurological observations are being completed following an unwitnessed fall or a witnessed 'blow' to the head and that staff training records show that staff have been educated in the completion of neurological observations. Provide

and care.		exception was noted in relation to the recording of neurological observations following unwitnessed falls or incidents involving a witnessed ‘blow’ to the head. The service’s policy clearly outlines the required timeframes for conducting neurological observations in such cases. A sample of accident/incident forms from a one-month period were reviewed, including four unwitnessed falls and one incident involving a witnessed ‘blow’ to the head. Three of these were examined in detail. Of the three, all had initial neurological observations taken; one had no further neurological observations recorded, while the other two had incomplete documentation—one with only three sets of observations recorded, and the other with four, falling short of policy requirements. An additional concern was noted regarding the internal audit process. Internal audits had not been completed in accordance with the established audit schedule. However, where audits had been undertaken, corrective actions were generated and appropriately addressed.	Additionally, the internal audit schedule has not been consistently followed.	evidence that the annual internal audit schedule has been followed through the provision of complete internal audits to match the internal audit schedule. 90 days
Criterion 2.2.6	PA	Discussion with the current owner of the facility and the FM	The FM of the facility does not fully understand or comply	Provide evidence that the FM has sought information and/or education to fully

Service providers shall understand and comply with statutory and regulatory obligations in relation to essential notification reporting.	Moderate	evidenced some understanding of statutory and regulatory obligations in relation to essential notification reporting, but neither were able to accurately explain all aspects of essential notifications. The FM had no knowledge of the change to reporting which required notification of Severity Assessment Code (SAC) 1 and 2, and pressure injury (stage three and above) to the Health Quality & Safety Commission/Te Tāhū Hauora (HQSC). A five-day telephone outage in May 2025 was not reported to HealthCert (at the Ministry of Health/Manatū Hauora) until this was brough to the attention of the FM on the day of audit. The current owner of the facility had completed a change of manager notification and sent this to HealthCert with incorrect information (the notification advised that the manager was a permanent employee when they were in fact on a casual contract). Given there is a likelihood of change of owner in the near future, who was able to describe essential notification, there is no reason for the current owner to further understand essential notifications (unless the sale does not go ahead); the FM, however, will need to upskill in this area.	with statutory and regulatory obligations in relation to essential notification reporting.	understand and comply with statutory and regulatory obligations in relation to essential notification reporting. 90 days
Criterion 2.3.1	PA	Staffing numbers are currently sufficient for the resident	Contracting of staff members to move from the current to	Provide evidence that sufficient staff have been contracted by the prospective

Service providers shall ensure there are sufficient health care and support workers on duty at all times to provide culturally and clinically safe services.	Moderate	population; however, no steps have yet been taken to transfer employment to the prospective owner of the facility. This process is due to start shortly given the proposed handover date of 1 July 2025. The current and prospective owners are aware of the issue and are actively working to amend the situation. In addition to this, 20 of the staff have been employed on casual contracts in anticipation of the sale, including the FM (who has a casual contract by choice). Twenty-three (23) staff work in the secure dementia unit from time to time. Of these, only three have completed the NZQA programme required, seven have commenced the programme but have not completed in the required timeframes (one was enrolled as early as 2015), and 13 have not been enrolled (the earliest has been working in the unit since 2022 but one is a new staff member).	the prospective new provider has not yet occurred. Not all staff who work in the secure dementia care unit of the facility have completed or been enrolled in the required NZQA programme for the service in the appropriate timeframes.	owner of the service on a permanent employment basis to meet the clinical and cultural needs of the resident population. Provide evidence that there are sufficient staff qualified in the NZQA programme to meet the needs of residents in the secure dementia care area of the facility. 30 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	PA Moderate	With the exception of medication competency (which has been completed for all staff administering and checking medication) and staff orientating to the service, annual competency assessments have not been consistently completed for all staff. These include health and safety,	Not all staff have completed all the annual competencies required and there is no process currently in use to record completion of competency for staff.	Provide evidence that a process has been implemented to record competency completion for all staff and that all staff have completed the competencies required annually. 90 days

needs of people equitably.		cultural safety, moving and handling, infection control (including personal protective equipment (PPE) use and hand hygiene), and restraint. There is currently no process in place for monitoring competency completion.		
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	An electronic learning management system, purchased from an external provider, has been acquired to support and document ongoing staff education. The system is appropriate and relevant to the needs of the service. However, it has not yet been fully implemented, and there is currently no formalised plan in place for the delivery of education to staff on an annual or biennial basis. Since the last (surveillance) audit in November 2024, only three education sessions have been delivered; on incontinence products (11 participants), sensory changes in older adults with dementia (seven participants), and observation and reporting in aged care (15 participants). Little of the education provided meets the requirements of the Nga Paerewa Standard and the facility's contracts with Te Whatu Ora.	There is no formal education plan in place to meet the requirements of the Ngā Paerewa Standard and the facility's contracts with Te Whatu Ora. A system for delivering and recording a relevant education programme for staff requires implementation.	Provide evidence of a formal education plan to meet the requirements of the Ngā Paerewa Standard and the requirements of the facility's contracts with Te Whatu Ora. Provide evidence that the system for delivering and recording of relevant education for staff has been implemented. 90 days

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	Six staff files were reviewed. There was evidence of curriculum vitae (CV) in most files, contracts (though many were casual – refer criterion 2.3.1), signing of confidentiality agreements and the code of conduct, and checking of qualifications. Visas (where appropriate) were current. Reference checking had not been completed in any files, as required in policy, and given the potential vulnerability of residents in the service.	In the files sighted, no staff had reference checking completed as per policy.	Provide evidence that all staff entering the service have been reference checked. 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	Of the six staff files reviewed, three did not have job descriptions in place (including the FM for their FM role and their role as the infection control nurse and the restraint coordinator refer criteria 5.2.1 and 6.1.3).	Not all staff had a job description in place for their role(s) in the files sighted.	Provide evidence that all staff have a job description in place for all of their roles in the service. 90 days
Criterion 2.4.5 Health care and support workers shall have the opportunity to discuss and review performance at defined intervals.	PA Moderate	Staff interviewed reported that performance appraisals had been conducted; however, this was not supported by documentation in the personnel files reviewed. The FM confirmed that performance appraisals are not being	Performance appraisals for staff are not being conducted annually.	Provide evidence that all staff have had a performance appraisal conducted annually. 90 days

		consistently completed on an annual basis. Of the six staff files reviewed, none contained evidence of a performance appraisal completed in 2024/2025. One staff member had a documented appraisal dated 2021, and another had an appraisal completed in 2023.		
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 Low	Files reviewed evidenced residents in both the rest home and secure dementia care services had an activities assessment that identified the residents' interests, skills, and strengths. There were activities plans in place, with a diverse programme provided to address these. Residents in the secure dementia care unit, however, have no plan in place that identifies the residents' previous routines or lifestyle patterns over a 24-hour period. As a result, opportunities to maintain and support residents' familiar lifestyle practices were not being facilitated.	The residents in the secure dementia care unit had no 24-hour care plan in place that addressed the residents' previous lifestyle patterns and routines, to enable the residents' previous lifestyle patterns to be maintained.	Provide evidence that the residents in the secure dementia care unit have a 24-hour care plan in place that addresses the residents' previous lifestyle patterns and routines. 180 days
Criterion 4.1.2 The physical environment, internal and external, shall be safe and accessible,	PA Moderate	Several security issues related to the garden areas used by residents in the secure dementia care unit were identified. The main garden space lacks a fully secure	There are two environmental areas which require attention. Firstly, the garden areas in the secure dementia care area need to be made secure,	Provide evidence that security issues in the secure dementia care garden areas have been addressed and that refurbishment of the laundry has taken

minimise risk of harm, and promote safe mobility and independence.		fence; portions of the fencing are made of wire with staves that can be easily pushed over. In addition to this, a raised garden bed and pergola within the main garden provide opportunities for residents to climb and potentially exit the secured area. A secondary garden area used by residents also has fencing that is potentially climbable. While the facility has implemented security measures to allow supervised access to the main garden, residents can only use this space when accompanied by a staff member. This arrangement limits residents' ability to access outdoor areas safely and independently. The current setup does not adequately support safe, autonomous access to outdoor environments, which is important for wellbeing and quality of life. A further issue relates to the laundry area of the facility. The area is small and untidy and requires refurbishment. Fans in the area were dusty, with one fan having the safety cover broken. Walls and cupboards require painting or replacement to maintain infection control standards (paint was flaking or chipped). There was PPE available in the area, with gloves and aprons reasonably accessible, but face shields for	and secondly, the laundry area requires refurbishment with easy availability for PPE.	place and facilitates easy access to PPE. 90 days

		use when sluicing soiled linen were on a very high shelf and were not accessible for staff. Staff confirmed they do not use them as they cannot reach them.		
Criterion 4.1.3 There shall be adequate personal space that is safe and age appropriate, and has accessible areas to meet relaxation, activity, lounge, and dining needs.	PA Low	The lounge area in the secure dementia care unit serves multiple functions, including leisure, dining, and recreational activities. When all residents are present, the space becomes crowded, limiting ease of movement and comfort. Additionally, there is an insufficient number of soft, comfortable chairs available for residents. The existing seating consists primarily of unpadded dining chairs, which are not conducive to resident comfort, particularly for those who require extended periods of seated support. This environment does not fully support the comfort and wellbeing expected in a dementia care setting.	There is an insufficient amount of soft furniture in the lounge/dining area of the secure dementia area to promote the comfort of residents during leisure and recreation activities.	Provide evidence that the lounge/dining area of the secure dementia care area has been reconfigured/refurbished to provide comfortable seating for the residents. 180 days
Criterion 4.2.4 Service providers shall ensure health care and support workers are able to provide a level of first aid and emergency treatment appropriate for the degree of risk associated with the	PA Low	Twenty staff members at the facility hold current first aid certification, including those responsible for transporting individuals in the facility van. A review of four weeks of staff rosters revealed that all morning and afternoon shifts were consistently covered by first aid	Not all staff on four weeks of rosters had first aid certification.	Provide evidence that first aid certified staff are rostered 24/7. 90 days

provision of the service.		certified staff. However, eight overnight shifts during this period were not covered by personnel with first aid certification. This issue was identified during the audit, and the facility has since scheduled relevant night staff to attend a first aid training course later this month to address the gap.		
Criterion 4.2.7 Alternative essential energy and utility sources shall be available, in the event of the main supplies failing.	PA Moderate	Civil defence food, medical, and safety supplies are available at the facility. However, there is currently no established system for regularly checking these supplies to ensure they are complete and in working order. Regional guidelines recommend emergency water storage of four litres per person per day for a minimum of three days. The facility currently stores 60 litres of water, which falls short of the recommended amount.	Emergency supplies are not being checked on a regular basis, and the current water storage is insufficient to meet the recommended regional guidelines.	Provide evidence that a formal regime has been put in place to regularly check emergency supplies and that the availability of water in storage is sufficient to meet the recommended regional guidelines. 90 days
Criterion 5.2.1 There is an IP role, or IP personnel, as is appropriate for the size and the setting of the service provider, who shall: (a) Be responsible for overseeing and	PA Moderate	The FM has assumed responsibility for implementing the programme, with reporting lines to the current owner of the facility. The FM has no job description for the role and has had no recent training in IP or AMS.	There is currently no job description in place for the ICN position at Ōhope. Additionally, the current incumbent has not undertaken recent training in IC and AMS, which is necessary to competently oversee the IP and AMS	Provide evidence that the ICN at Ōhope has a job description for the role and has had recent training in IC and AMS so that they can competently oversee the IP and AMS programmes. 90 days

coordinating implementation of the IP programme; (b) Have clearly defined responsibility for IP decision making; (c) Have documented reporting lines to the governance body or senior management; (d) Follow a documented mechanism for accessing appropriate multidisciplinary IP expertise and advice when needed; (e) Receive continuing education in IP and AMS; (f) Have access to shared clinical records and diagnostic results of people.			programmes.	
Criterion 5.2.2 Service providers shall have a clearly defined and documented IP programme that shall be: (a) Developed by those with IP expertise; (b) Approved by the governance body; (c) Linked to the quality improvement programme; and (d) Reviewed and	PA Low	There is an IP and AMS programme in place at Ōhope, implemented by an external advisory company. The programme has been approved by the current owner and is linked to the quality improvement programme. The programme has not been reviewed annually as required.	The IP and AMS programme has not been reviewed annually.	Provide evidence that the IP and AMS programme has been reviewed, and that there is a process in place to ensure the programme is reviewed annually. 180 days

reported on annually.				
Criterion 5.2.6 Infection prevention education shall be provided to health care and support workers and people receiving services by a person with expertise in IP. The education shall be: (a) Included in health care and support worker orientation, with updates at defined intervals; (b) Relevant to the service being provided.	PA Moderate	Although the orientation programme includes the principles of IPC and orientation had been completed in all staff files sighted, there had been no other IP and AMS education provided to staff in either 2024 or 2025 other than 'donning and doffing' demonstrations.	IP and AMS education had not been completed in 2024 or 2025 by a person with expertise in IP.	Provide evidence that IP and AMS education has been completed by a person with expertise in IP, and that IP and AMS education is included in the facility's education plan. 180 days
Criterion 5.2.7 A person with IP expertise shall be involved in procurement processes for equipment, devices, and consumables used in the delivery of health care.	PA Moderate	The FM's advice has been sought in decision-making related to procurement relevant to processes for equipment, devices and consumables. However, there are no staff at Ōhope with specific expertise in IP or AMS involved in these decisions, which limits the ability to fully consider infection control implications in such processes. Policy development has been undertaken by an external provider with expertise in IP and AMS, helping to ensure alignment with best practice in this area.	There are no staff at Ōhope who have expertise in IP or AMS to support decision-making related to procurement.	Provide evidence there is a staff member with IP and AMS expertise advising on procurement processes. 180 days

Criterion 5.5.4 Service providers shall ensure there are safe and effective laundry services appropriate to the size and scope of the health and disability service that include: (a) Methods, frequency, and materials used for laundry processes; (b) Laundry processes being monitored for effectiveness; (c) A clear separation between handling and storage of clean and dirty laundry; (d) Access to designated areas for the safe and hygienic storage of laundry equipment and chemicals. This shall be reflected in a written policy.	PA Moderate	Policies and procedures were in place for the management of laundry work and, in general, methods, frequency, and materials used for laundry processes were adhered to. The exception to this was through laundry staff not using appropriate PPE (an apron) when transferring soiled laundry into the washing machine; gloves were used. This is an IC risk when the person later empties the dryer of clean clothes and helps to make residents' beds. No education on IPC principles has been given to staff in 2024 or 2025.	Appropriate PPE is not being used by laundry staff when loading the washing machine with soiled clothing.	Provide evidence that laundry staff have received education in appropriate PPE use when loading washing machines with soiled clothing. 90 days
Criterion 6.1.3 There shall be an executive leader who is responsible for ensuring the commitment to restraint minimisation and elimination is implemented and	PA Moderate	Ōhope has not used restraint for at least 12 years. The FM, who is a RN and is the clinical lead for the service and works as the restraint coordinator. The FM has not undertaken specialised education relevant to the role as the restraint coordinator within the	There is no job description in place to guide the practice of the RN working as the restraint coordinator and no education specific to the role has been undertaken.	Provide evidence that there is a job description in place to guide the practice of the RN working as the restraint coordinator and that education specific to the role has been undertaken. 90 days

maintained.		last two years. and there is no job description for the role in place to guide practice.		
Criterion 6.1.6 Health care and support workers shall be trained in least restrictive practice, safe practice, the use of restraint, alternative cultural-specific interventions, and de-escalation techniques within a culture of continuous learning.	PA Moderate	At interview, staff were able to explain least restrictive practice, safe restraint practice, alternative cultural-specific interventions, and de-escalation techniques accurately and well; however, staff have not been trained in the least restrictive practice, safe restraint practice, alternative cultural-specific interventions, and de-escalation techniques in 2024 or 2025. This was a finding at the last (surveillance) audit.	Staff have not been trained in the least restrictive practice, safe restraint practice, alternative cultural-specific interventions, and de-escalation techniques in 2024 or 2025.	Provide evidence that staff have been trained in the least restrictive practice, safe restraint practice, alternative cultural-specific interventions, and de-escalation techniques. 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 audit.

No data to display

End of the report.