# Experion Care NZ Limited - Wensley House

## Introduction

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

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

The abbreviations used in this report are the same as those specified in section 0.4 of the Ngā Paerewa Health and Disability Services Standard (NZS8134:2021).

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

The specifics of this audit included:

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| **Legal entity:** | Experion Care NZ Limited |
| **Premises audited:** | Wensley House |
| **Services audited:** | Rest home care (excluding dementia care) |
| **Dates of audit:** | Start date: 28 April 2022 End date: 29 April 2022 |

**Proposed changes to current services (if any):** None

**Total beds occupied across all premises included in the audit on the first day of the audit:** 32

# Executive summary of the audit

## Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six sections contained within the Ngā Paerewa Health and Disability Services Standard:

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

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

**Key to the indicators**

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

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

## General overview of the audit

Wensley House provides rest home level of care for up to 43 residents. There were 32 residents on the day of audit.

This certification audit was conducted against the Ngā Paerewa Health and Disability Services Standards 2021 and the contracts with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, interviews with residents, management, and staff.

The general manager is experienced and is supported by the owner. Feedback from residents was positive about the care and the services provided. An induction and competency programme are in place to provide staff with appropriate knowledge and skills to deliver care.

This certification audit identified that improvements are required in relation to communication, the complaints process, review of business goals, aspects of the quality system, education, timeframes, care planning, medication management, emergency management checks, aspects of food services, pandemic planning, outbreak management, and cleanliness.

## Ō tatou motika | Our rights

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

Wensley House provides an environment that supports resident rights. Staff demonstrated an understanding of residents' rights and obligations. There is a Māori health plan as part the policies and procedures. There were no Māori residents at the time of the audit.

Residents receive services in a manner that considers their dignity, privacy, and independence. The staff were observed listening and respecting the voices of the residents and effectively communicating with them about their choices.

Residents and family interviewed stated they are kept informed, and complaints are addressed by the service.

## Hunga mahi me te hanganga | Workforce and structure

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

The business plan includes a mission statement and operational objectives. The service has documented quality and risk management. Meetings occur as scheduled. Quality data is collated and analysed.

There is a staffing and rostering policy. Human resources are managed in accordance with good employment practice. A role specific orientation programme is in place. Staff completed role specific competencies and education.

The service ensures the collection, storage, and use of personal and health information of residents is secure, accessible, and confidential.

## Ngā huarahi ki te oranga | Pathways to wellbeing

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

There is an admission package available prior to or on entry to the service. Care plans viewed demonstrated service integration. Resident files included medical notes by the general practitioner.

Registered Nurses and senior caregivers are responsible for administration of medicines. Electronic medicine charts are in use.

An activities coordinator provides and implements an interesting and varied activity programme. The programme includes outings, and meaningful activities that meet the individual recreational preferences.

Residents' food preferences and dietary requirements are identified at admission and all meals are cooked on site. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines. The service has a current food control plan.

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

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| Includes 2 subsections that support an outcome where Health and disability services are provided in a safe environment appropriate to the age and needs of the people receiving services that facilitates independence and meets the needs of people with disabilities. | | Some subsections applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |

The building holds a current warrant of fitness. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating, and shade. There is a mix of bedrooms with shared ensuites and others with hand basin facilities. There are communal shower rooms with privacy locks or signage. Rooms are personalised. Documented systems are in place for essential, emergency and security services. Staff have planned and implemented strategies for emergency management including Covid-19.

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

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

Infection prevention policies are in place. Documentation evidenced that relevant infection control education is provided to all staff as part of their orientation and as part of the ongoing in-service education programme. Standardised definitions are used for the identification and classification of infection events. Covid-19 response plans are in place and the service has access to personal protective clothing (PPE) supplies. There has been one Covid-19 outbreak. There are documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. Chemicals are stored safely throughout the facility. Documented policies and procedures are in place for cleaning and laundry services.

## Here taratahi | Restraint and seclusion

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

The restraint coordinator is the general manager during the absence of a full-time registered nurse. There are no restraints used at Wensley House. Maintaining a restraint-free environment is included as part of the education and training plan. The service considers least restrictive practices, implementing de-escalation techniques and alternative interventions, and would only use an approved restraint as the last resort.

## 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) |
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| **Subsection** | 0 | 15 | 0 | 4 | 8 | 0 | 0 |
| **Criteria** | 0 | 118 | 0 | 4 | 12 | 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) |
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| **Subsection** | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 |

# Attainment against the Ngā Paerewa Health and Disability Services Standard

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

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

For more information on the standard, please click here.

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

| Subsection with desired outcome | Attainment Rating | Audit Evidence |
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| Subsection 1.1: Pae ora healthy futures<br><br>Te Tiriti: Māori flourish and thrive in an environment that enables good health and wellbeing.<br><br>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 | A cultural awareness and cultural safety and responsiveness policy for Māori residents is documented for the service. This policy acknowledges the Te Tiriti O Waitangi as a founding document for New Zealand and the roles and responsibilities for successfully implementing the policy.<br><br>The document recognises the importance of the partnership with tāngata whenua under the Treaty. This document includes a cultural assessment and Māori care plan that includes the four elements of Te Whare Tapa Whā. They include te tahu wairua (spiritual wellbeing), te taha hinengaro (mental and emotional wellbeing), te taha tinana (physical wellbeing), and te taha whānau (whānau and social wellbeing). The service had no residents who identified as Māori.<br><br>The owner confirmed that the service supports increasing Māori capacity by employing more Māori staff members. At the time of the audit the general manager reported one staff member identifies as |

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| | | Māori.<br><br>Five care staff interviewed (three caregivers, one activities coordinator and one casual registered nurse [RN]) described how care is based on the resident's individual values and beliefs. The cultural awareness and safety policy recognise community links with Te Piki Oranga and whakatu marae, these links are not yet established.<br><br>There is a Māori Good employer policy to state the services commitment on promoting a Māori workforce. |
| Subsection 1.2: Ola manuia of Pacific peoples in Aotearoa<br><br>The people: Pacific peoples in Aotearoa are entitled to live and enjoy good health and wellbeing.<br><br>Te Tiriti: Pacific peoples acknowledge the mana whenua of Aotearoa as tuakana and commit to supporting them to achieve tino rangatiratanga.<br><br>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 | On admission all residents state their ethnicity. There is a Pacific Peoples policy and the commitment to achieve tino rangatiratanga (self-determination, autonomy).<br><br>The owner advised that whānau members of Pacific residents will be encouraged to be present during the admission process including completion of the initial care plan. There were no residents that identified as Pasifika. Individual cultural beliefs are not always evidenced as documented in resident care plan or activities plan (link 3.2.3).<br><br>The service is actively recruiting new staff. The general manager described how they would encourage and support any staff that identified as Pasifika through the employment process. There are currently no staff that identify as Pasifika.<br><br>Interviews with eight staff (five care staff, one maintenance, one housekeeper, one kitchen manager), five residents, and clinical documentation reviewed identified that the service puts people using the services, families, and the Richmond community at the heart of their service.<br><br>The facility is working towards the focussed recruitment of Pacific staff. There are currently no staff that identify as Pasifika. |
| Subsection 1.3: My rights during service delivery | FA | Details relating to the Health and Disability Commissioner's (HDC) Code of Health and Disability Consumer Rights (the Code) are |

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| The People: My rights have meaningful effect through the actions and behaviours of others.<br><br>Te Tiriti: Service providers recognise Māori mana motuhake (self-determination).<br><br>As service providers: We provide services and support to people in a way that upholds their rights and complies with legal requirements. | | included in the information that is provided to new residents and their families/whānau. The general manager or RN discusses aspects of the Code with residents and their relatives on admission.<br><br>The Code is displayed on a noticeboard near the entrance to the facility in English and te reo Māori.<br><br>Discussions relating to the Code are held during the three-monthly resident/whānau meetings. The five residents and three relatives interviewed reported that the residents' rights are being respected and the service is flexible to meet their individual needs. Interactions observed by the auditors between staff and residents were respectful.<br><br>Information about the Nationwide Health and Disability Advocacy Service is available to residents when on the residents' noticeboard and at the entrance to the facility. There are links to spiritual support including church services and a chaplain. Residents interviewed confirmed their relatives are treated with respect.<br><br>The caregivers interviewed described how they arrange their time of their shift to ensure they are flexible to meet each resident's needs and choice. Staff are trained on the Code at orientation. This training is ongoing through the annual education and training programme which includes (but is not limited to) understanding the role of advocacy services. Staff completed training in February 2022 and Aged Concern presented The Code to the residents at a meeting in 2021. Advocacy services are not linked to the complaints process (link 1.8.2). Information about accessing advocacy services information is available in the information presented to residents and families at the time of entry to the service.<br><br>Plans are underway to ensure that the service recognises Māori mana Motuhake through their cultural training programmes. |
| Subsection 1.4: I am treated with respect<br><br>The People: I can be who I am when I am treated with dignity and | FA | The care staff interviewed described how they support residents to choose what they want to do and understand what Te Tiriti o Waitangi means to their practice with examples provided when interviewed. It is expected that residents identifying as Māori will experience |

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| respect.<br><br>Te Tiriti: Service providers commit to Māori mana motuhake.<br><br>As service providers: We provide services and support to people in a way that is inclusive and respects their identity and their experiences. | | physical, spiritual, mental, and emotional wellbeing and have control over their own destinies/outcomes, as do all residents.<br><br>Residents interviewed stated they had choice. Residents are supported to make decisions about whether they would like their whānau members to be involved in their care or other forms of support.<br><br>Residents have control over and choice over activities they participate in.<br><br>On the day of the audit it was observed that the residents in Wensley House have a high level of physical independence, were out of their rooms and gathered in the big lounge for morning tea. A selection of residents interviewed confirmed that they enjoy and appreciate their independence.<br><br>The management and staff interviewed reported, Age Concern provided training to staff in February 2022 related to the Code of rights, advocacy service and abuse and neglect.<br><br>It was observed that residents are treated with dignity and respect. Satisfaction surveys completed in March 2022 confirmed that residents and families are treated with respect. This was also confirmed during interviews with residents.<br><br>A sexuality and intimacy policy is in place. Staff interviewed stated they respect each resident's right to have space for intimate relationships.<br><br>Staff were observed to use person-centred and respectful language with residents. Residents interviewed were positive about the service in relation to their values and beliefs being considered and met. Privacy is ensured and independence is encouraged.<br><br>Residents' files and care plans identified residents preferred names. Values and beliefs and spiritual preferences are not evidenced as gathered on admission, therefore not integrated into the residents' |

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| | | care plans (link 3.2.3). A spirituality policy is in place, however not evidenced as being reviewed regularly (link 2.2.3).<br><br>There is a policy that recognises tikanga and the care of tūpāpaku. Work is underway to actively promote te reo Māori and tikanga Māori, and to ensure staff attend specific cultural training that covers Te Tiriti o Waitangi and tikanga Māori and ensure that staff participate in te ao Māori. |
| Subsection 1.5: I am protected from abuse<br><br>The People: I feel safe and protected from abuse.<br><br>Te Tiriti: Service providers provide culturally and clinically safe services for Māori, so they feel safe and are protected from abuse.<br><br>As service providers: We ensure the people using our services are safe and protected from abuse. | FA | The abuse & neglect policy is being implemented, however, has not been reviewed on a regular basis (link 2.2.3). There is a clearly documented procedure of reporting to follow should they become aware of any abuse.<br><br>The company policies prevent any form of discrimination, coercion, harassment, or any other exploitation. Inclusiveness of all ethnicities, and cultural days are initiated to celebrate diversity.<br><br>Staff complete education on orientation and annually as per the training plan on how to identify abuse and neglect. Staff are educated on how to value the older person showing them respect and dignity. All residents and families interviewed confirmed that the staff are very caring, supportive, and respectful. Relatives interviewed confirmed that the care provided to their relative is of a reasonable standard.<br><br>There is an accurate listing of the personal effects documented at admission that is brought into this facility. Residents interviewed stated staff respect their possessions. There is a comfort fund. Financial statements are clear and easy to read.<br><br>Police checks are completed as part of the employment process. A staff code of conduct/house rules is discussed during the new employee's induction to the service. Professional boundaries are defined in job descriptions and covered at orientation. Interviews with the casual RN and caregivers confirmed their understanding of professional boundaries, including the boundaries of their role and responsibilities. |

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| | | Policies cover (but are not limited to) the harassment, discrimination and bullying policy, and the professional boundaries policy (staff scope of responsibilities). Work is underway to ensure that a strengths-based and holistic model is prioritised to ensure wellbeing outcomes for their Māori residents. |
| Subsection 1.6: Effective communication occurs<br><br>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.<br><br>Te Tiriti: Services are easy to access and navigate and give clear and relevant health messages to Māori.<br><br>As service providers: We listen and respect the voices of the people who use our services and effectively communicate with them about their choices. | PA Low | Information is provided to residents/relatives on admission. Monthly resident meetings identify feedback by residents and consequent follow-up by the service to address any deficiencies. Resident meeting minutes are accessible for residents to access.<br><br>Policies and procedures relating to accident/incidents, complaints, and open disclosure policy alert staff to their responsibility to notify whānau/next of kin of any accident/incident or changes in health that occurs. Next of kin notification on accident/incident forms and day to day family involvement were inconsistently recorded on forms and progress notes. Three relatives interviewed and five residents stated they feel informed of any changes that happens to their relative/themselves and they are involved in planning care.<br><br>An interpreter policy and contact details of interpreters is available in a policy. Interpreter services are used where indicated and when required and is available through the local public hospital. At the time of the audit, there were no residents who did not speak English.<br><br>Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The residents and whānau are informed prior to entry of the scope of services and any items that are not covered by the agreement.<br><br>The service communicates with other agencies that are involved with the resident such as the DHB specialist services. The delivery of care includes a multidisciplinary team and residents/relatives provide consent and are communicated with in regard to services involved. The general manager described an implemented process around providing residents with time for discussion around care, time to |

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| | | consider decisions, and opportunity for further discussion, if required. |
| Subsection 1.7: I am informed and able to make choices<br><br>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.<br><br>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.<br><br>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 | Informed consent and advance directive policy and related form is in place. There are documented instructions for staff in the policy if the resident does not have an advanced directive in place. Discussions with caregivers and the RN confirmed that staff understand the importance of obtaining informed consent for providing personal care and accessing residents' rooms.<br><br>Informed consent processes are discussed with residents and families on admission. Written general consents for photographs, release of medical information, and medical cares were signed as part of the admission agreement. Indemnity and outing consent are scanned into the resident electronic file. There were consent forms for flu and Covid-19 vaccinations given.<br><br>The service welcomes the involvement of whānau in decision making where the person receiving services wants them to be involved,<br><br>Training has been provided to staff around code of rights, informed consent and EPOAs in February 2022.<br><br>Enduring power of attorney (EPOA) evidence is filed in the residents' electronic charts and activated where required. Advance directives for health care including resuscitation status had been completed where residents were deemed to be competent. Where residents were deemed incompetent to make a resuscitation decision the GP had made a medically indicated resuscitation decision. Resident files/progress notes lack documented evidence that where appropriate, the service actively involve whānau in decisions including consent that affect their relative's lives (link 3.2.1).<br><br>The service is working towards a process to apply the appropriate best practice tikanga guidelines in relation to consent. |
| Subsection 1.8: I have the right to complain<br><br>The people: I feel it is easy to make a complaint. When I complain | PA Moderate | The complaints procedure is provided to residents and relatives on entry to the service and is part of the welcome pack. The general manager keeps a record of written complaints, actions taken, and |

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| I am taken seriously and receive a timely response.<br><br>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.<br><br>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. | | resolution, for written complaints only. Work is underway to ensure that the complaints process works equitably for Māori.<br><br>The complaints register was sighted, however not all known complaints were recorded in the register. The register evidenced a total of three written complaints; one complaint was logged in a complaint register for 2020 (since last audit) and two for 2021/2022 YTD. In relation to these complaints received, timeframes for responding to the complaint met timeframes determined by HDC. Corrective actions were documented for these complaints and discussed in meetings.<br><br>One complaint was lodged through the DHB (March 2021) and noted to be closed off. There is an open complaint dated May 2021 lodged through the DHB has not received a response after a DHB request to respond. The documentation related to both complaints were not noted in the complaints folder and no progress/ongoing monitoring on the corrective actions required recorded (link 2.2.4).<br><br>The general manager stated that she addresses concerns as they arise and has received few complaints. Staff are informed of verbal and written complaints in the quality and staff meetings (meeting minutes sighted) however it is unclear if and how the verbal complaints were resolved and what the follow-up corrective actions were.<br><br>Discussions with residents confirmed they can raise complaints without feeling intimidated. Residents have a variety of avenues they can choose from to make a complaint or express a concern however complaints forms were not easily accessible for residents and families. Resident meetings are held three monthly where residents can raise any concerns with the general manager.<br><br>Information regarding independent support and access to the Nationwide Health and Disability Advocacy Service were not available as part of the complaints process. |

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| Subsection 2.1: Governance<br><br>The people: I trust the people governing the service to have the knowledge, integrity, and ability to empower the communities they serve.<br><br>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.<br><br>As service providers: Our governance body is accountable for delivering a high quality service that is responsive, inclusive, and sensitive to the cultural diversity of communities we serve. | PA Low | Experion Care NZ Limited was incorporated in 2015 and acquired Wensley House in July 2017. Experion Care currently owns another six medium sized care facilities (in Gore, Feilding and Napier).<br><br>Wensley House is located in Richmond, is certified for 43 rest home level beds (30 in the rest home and 13 serviced apartments). At the time of the audit there were 27 residents in the care facility and five in the serviced apartments). All residents except two were on the age-related residential care agreement (ARRC). Two residents were under 65 and under a mental health contract.<br><br>The 2018-2022 business plan outlines the business core values (respect for everyone, deliver, drive excellence) direction and objectives. The services values are displayed in the facility lounge.<br><br>There is no board of directors or formal governance structure. The executive director (sole owner) is supported by an accounts/business manager, human resources consultant and legal support. The owner interviewed has been based in India for the last two years due to the Covid-19 pandemic and supports the facility remotely.<br><br>The general manager holds an MBA qualification has been in the role since 2016 and has previous experience in health care management including dementia care. A general manager (RN) is responsible for the day-to-day activities of the facility and is employed fulltime Monday to Friday. Responsibilities and accountabilities of the general manager position are defined in a job description and individual employment agreement. Interview with the general manager confirmed their understanding of the sector, regulatory and reporting requirements. The general manager stated she was previously supported by a full-time clinical leader (RN) that had responsibilities to oversee the clinical management of the residents.<br><br>The full-time clinical leader role is vacant (since October 2021) and a casual RN is currently in the role for 10-16 hours per week (Thursday and Friday).<br><br>The business plan includes a mission, operational objectives, |

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| | | however, goals are not documented as regularly reviewed.<br><br>The owner interviewed confirmed each facility is working as an independent business unit and work is underway to improve peer support for the general manager and RN. The owner is actively recruiting for a national quality role overseeing the compliance of all Experion Care NZ limited facilities within the next six months.<br><br>The general manager provides a monthly report to the owner and includes, health and safety, staffing, occupation, quality, and risk related issues. The general manager confirmed she has weekly phone or zoom meetings with the owner.<br><br>Work is underway to ensure that the service collaborates with mana whenua in business planning and service development to improve outcomes and achieve equity for Māori; to identify and address barriers for Māori for equitable service delivery, and to ensure that the owner and general manager attend cultural training. |
| Subsection 2.2: Quality and risk<br><br>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.<br><br>Te Tiriti: Service providers allocate appropriate resources to specifically address continuous quality improvement with a focus on achieving Māori health equity.<br><br>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 | Wensley House has a quality and risk management programme developed by an external consultant. A strengths, weakness, opportunities, and threats (SWOT) analysis is included as part of the business plan. The quality and risk management systems include performance monitoring through internal audits and through the collection of clinical indicator data. There was no evidence of documented quality objectives for 2021/2022.<br><br>There is an internal audit/survey policy implemented as required. Adverse event data is collected manually with evidence of data and graphs shared in the quality and staff meetings. There were no resident and whānau satisfaction survey results available for 2021. Surveys completed in March 2022 were not yet analysed and collated.<br><br>Monthly staff meetings occurred as planned and provide an avenue for discussions in relation to (but not limited to) quality data, health and safety, infection control/pandemic strategies, complaints received (if any), staffing, and education. Corrective actions related to falls, medication errors, health and safety and verbal complaints are |

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| | | recorded to address service improvements, however progress and timely sign off was inconsistently recorded.<br><br>There are procedures to guide staff in managing clinical and non-clinical emergencies. Documents are developed by an external consultant; new documents were not always uploaded to the system. Documents requested on the day of the audit were difficult to locate.<br><br>A health and safety system is in place with the general manager the health and safety officer. Hazard identification forms and an up-to-date hazard register were sighted. The general manager and maintenance person implement health and safety policies. There are manual handling training sessions for staff. In the event of a staff accident or incident, a debrief process is documented on the accident/incident form.<br><br>Individual falls prevention strategies are in place for residents identified at risk of falls. There were two residents in the last six months identified as frequent fallers. One resident was assessed for a higher level of care. Strategies implemented to reduce the frequency of falls include regular toileting of residents who require assistance and clinical review of underlying medical conditions. A physiotherapist is available when required. There was no falls prevention education in the last 24 months provided (link 2.3.4).<br><br>Incident/accidents are recorded. Ten accident/incident forms reviewed (witnessed and unwitnessed falls, skin tears, behaviour) indicated that the forms are not always completed in full. Incident and accident data is collated monthly and analysed. Results are discussed in the monthly combined quality and staff meetings. Not all events involving a resident reflected a clinical assessment and follow-up by a registered nurse (link 3.2.5). Neurological observations were not consistently recorded for unwitnessed falls (link 3.2.4).<br><br>Discussions with the general manager evidenced her awareness of their requirement to notify relevant authorities in relation to essential notifications. There has been one section 31 notification completed to notify HealthCERT related to a pressure injury on request of the |

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| | | planning and funding manager (although this was not a stage three or higher). There has been a Covid-19 outbreak in March 2022 (link 5.4.1). |
| Subsection 2.3: Service management<br><br>The people: Skilled, caring health care and support workers listen to me, provide personalised care, and treat me as a whole person.<br><br>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.<br><br>As service providers: We ensure our day-to-day operation is managed to deliver effective person-centred and whānau-centred services. | PA Low | There is a staffing policy that describes rostering. The roster provides sufficient and appropriate coverage for the effective delivery of care and support and meets contractual requirements (D17.3 e i-viii). Interviews with staff confirmed that although they are busy, overall staffing of caregivers is adequate to meet the needs of the residents. Staff reported moderate levels of staff turnover. There is an advertisement in place for a casual RN but not a replacement for the full time RN (employed until October 2021).<br><br>The general manager (registered nurse) is employed for 40 hours per week and on site from Monday to Friday. The role description is to provide operational oversight of the day-to-day activities within the facility including oversight of the key components of the quality and risk management system. A full time RN was previously employed (and left the role in October 2021) to provide clinical oversight (including interRAI, assessment and care planning) and support for the general manager (RN). Staff, residents, and family members interviewed reported the general manager to be available and responsive to their needs.<br><br>A casual RN has been employed since March 2021 and is currently supporting the facility and works Thursdays and Fridays up to 16 hours per week.<br><br>The general manager reported since October 2021 she took on the responsibility of being the backup RN and completes interRAI assessments for all residents, is responsible to be the restraint and infection control coordinator and the casual nurse will complete care planning documentation. The general manager is also on call six days a week including all weekends, the casual nurse is on call on a Thursday. Staff reported they call the on-call RN after hours in an event of an unwitnessed fall or clinical assessment/completion of neurological observations. The maintenance person (repair person) |

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| | | reported the general manager is on call for any maintenance issues.<br><br>Wensley House with 32 rest home level residents (27 in the care facility and five in the serviced apartments), is staffed with three caregivers on the AM shift (two from 7am to 3pm and one from 7am to 4pm).<br><br>Two caregivers are rostered on the PM shift (3pm to 11pm). Two caregivers are rostered on the night shift (one for the service apartments).<br><br>Staff interviewed reported the residents to have a high level of physical independence. The allocation sheet evidenced seven residents that require assistance with ADLs.<br><br>Staff are instructed to call an ambulance in the event of a medical emergency after hours.<br><br>There are separate cleaning staff (Monday to Wednesday 8am to 1.30pm) and also include a contractor cleaner for the serviced apartments Monday to Fridays and care facility on a Thursday and Friday. Caregivers assist with personal laundry duties and the maintenance person is responsible for the linen and towels.<br><br>Out of a total of 14 caregivers, four do not have a formal Careerforce qualification. Ten caregivers hold a level four qualification, three of them previous registered nurses in their country of origin. Staff interviewed confirmed they are supported to complete a formal Careerforce qualification.<br><br>A competent care provision policy is being implemented. Competencies completed over the past 12 months include a communication quiz, medication competency including insulin and controlled drug check, manual handling, food safety, handwashing, wound care, and fire evacuation. The service is working towards developing a cultural competency for staff.<br><br>There is no formal education planner documented. The following |

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| | | education was completed in the last 24 months related to EPOA, advance directives, first aid, medication management, pressure care and wound training, mouth and dental cares, fire safety including emergency management, health, and safety, Code of conduct, Code of Rights include informed consent abuse and neglect, sexuality and intimacy, chemical safety, manual handling, infection control, restraint minimisation and cultural safety. Caregivers reported they each had three one-on-one sessions in the use of PPE, training in pandemic planning/management and complaints management, this was recorded in their individual files. Work is underway to ensure that staff are encouraged to participate in learning opportunities that provide them with up-to-date information on Māori health outcomes and disparities, and health equity.<br><br>The service encourages all their staff to attend monthly meetings (e.g. combined staff meetings, quality meetings and H&S). Resident/whānau meetings are also held three- monthly, chaired by the general manager.<br><br>Training, support, performance, and competence are provided to staff to ensure health and safety in the workplace including manual handling, chemical safety, emergency management including (six-monthly) fire drills and personal protective equipment (PPE) training.<br><br>The general manager provided evidence of maintaining at least eight hours annually of professional development activities related to managing a rest home and includes infection control training. |
| Subsection 2.4: Health care and support workers<br><br>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.<br><br>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 | FA | There are human resources policies in place, including recruitment, selection, orientation and staff training and development. There is a human resources consultant that advises and supports the general manager on best employment practices. Staff files are held in the general manager's office in a locked filing cabinet. Six staff files reviewed (four caregivers, one casual RN and one activities coordinator) evidenced implementation of the recruitment process, employment contracts, police checking and completed orientation. Plans are in place for the formal collection and retention of staff |

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| of Māori.<br><br>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. | | ethnicity information during the employment process.<br><br>There are job descriptions in place for all positions that includes outcomes, accountability, responsibilities, authority, and functions to be achieved in each position.<br><br>A register of practising certificates is maintained for the podiatrist, GPs, dietitian, and RNs (including general manager). There is an appraisal policy. All staff who had been employed for over one year had appraisals completed.<br><br>The service has a role-specific orientation programme in place that provides new staff with relevant information for safe work practice and includes buddying when first employed. Competencies are completed at orientation. The service demonstrates that the orientation programmes support staff to provide a culturally safe environment for the residents. Volunteers have not been utilised due to Covid.<br><br>Information held about staff is kept secure, and confidential. At the time of the audit, ethnicity data was not being collected.<br><br>Staff reported that there has been moderate turnover of staff which had minimal impact on their wellbeing. Staff reported if it was not for the high level of physical independent residents it might have had an impact on their wellbeing. |
| Subsection 2.5: Information<br><br>The people: Service providers manage my information sensitively and in accordance with my wishes.<br><br>Te Tiriti: Service providers collect, store, and use quality ethnicity data in order to achieve Māori health equity.<br><br>As service provider: We ensure the collection, storage, and use of personal and health information of people using our services is accurate, sufficient, secure, accessible, and confidential. | FA | Resident information is held in a confidential manner. Resident files are held in a locked nurse's station. Hard copy information is held in a locked cupboard.<br><br>The resident files are appropriate to the service type and demonstrated service integration. Records are uniquely identifiable and legible. Signatures are documented and include the designation of the person providing the care intervention.<br><br>Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. |

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| Subsection 3.1: Entry and declining entry<br><br>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.<br><br>Te Tiriti: Service providers work proactively to eliminate inequities between Māori and non-Māori by ensuring fair access to quality care.<br><br>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' entry into the service is facilitated in a competent, equitable, timely and respectful manner. Admission information packs are provided for families and residents prior to admission or on entry to the service. The admission agreement aligns with all contractual requirements. Exclusions from the service are included in the admission agreement.<br><br>The residents interviewed stated that they have received the information pack and have received sufficient information prior to and on entry to the service. The service has policies and procedures to support the admission or decline entry process. Admission criteria is based on the assessed need of the prospective resident and the contracts under which the service operates. The general manager is available to answer any questions regarding the admission process. The service communicates with potential residents and whānau during the admission process. Declining entry would only be if there were no beds available or the potential resident did not meet the admission criteria. The service does not currently collect ethnicity information at the time of admission from individual residents. Cultural considerations are not routinely documented on admission or on the lifestyle profile. The facility does not currently identify entry and decline rates for Māori and is working on a process to collate this information. The general manager reported they are working towards establishing links to local Māori health practitioners and Māori health organisations to improve health outcomes for future Māori residents. |
| Subsection 3.2: My pathway to wellbeing<br><br>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.<br><br>Te Tiriti: Service providers work in partnership with Māori and whānau, and support their aspirations, mana motuhake, and whānau rangatiratanga.<br><br>As service providers: We work in partnership with people and | PA Moderate | The care plan policy and procedure guides staff around admission processes, required documentation including interRAI, risk assessments, care planning, the inclusion of cultural interventions, and timeframes for completion and review of care plans. The clinical documentation policy and business plan documented the model of care and the general manager stated the model of care is person centred and encourages and promotes independence.<br><br>Six resident rest home files were reviewed (five ARRC contract and one on a mental health contract [under 65]), including one rest home resident residing in a serviced apartment. A casual RN is responsible for conducting all assessments and for the development of care plans. |

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| whānau to support wellbeing. | | The general manager and a casual clinical nurse lead are responsible for all admissions. On interview resident and whānau confirmed involvement in the interRAI assessments and long-term care plans reviewed, however this is not always documented.<br><br>All residents have admission assessment information collected and an initial care plan, however not all were completed within required timeframes. The general manager (RN) advised that since the resignation of the permanent full time registered nurse six months ago, clinical input into interRAI assessments and care planning has been provided by a casual RN and the general manager (RN). Not all long-term care plans have been updated with identified changes in care needs, and not all interRAI assessments and care plan reviews have been completed within the required timeframes in the last year. Evaluations are scheduled to be completed six-monthly and all are up to date now, however these had not occurred as required for all of the six permanent resident files reviewed (one had not been at the service long enough to require a six-monthly evaluation).<br><br>The long-term care plan includes sections on mobility, continence, activities of daily living, nutrition, pain management, sleep, communication, medication, skin care, cognitive function, and behaviours. Risk assessments are conducted on admission relating to falls, pressure injury, continence, nutrition, and pain. A specific cultural assessment has not yet been implemented.<br><br>All residents had been assessed by the general practitioner (GP) within five working days of admission. The GP is scheduled to review all residents at least three-monthly however this has not always occurred. There is evidence the GP reviews residents earlier if required. There are two medical practises contracted to provide medical oversight. The general manager reported one GP attends the service weekly and as required for changes in health. The other two GPs have not been available to attend residents on site and the service has transported them to the medical rooms, however the GM reports it been difficult to secure appointments for routine medication reviews (link 3.4.2). All health concerns after hours are reported to the GM who contacts ambulance services for transport to the local hospital. The GPs were not available to talk to on the days of audit. |

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| | | The GM reported a good relationship with mental health clinical specialists and other specialists and stated referrals are initiated as needed. None of the residents' files reviewed evidenced allied health interventions. The GM stated the residents were transported to podiatry appointments, however there was no documentation to support this.<br><br>The service has access to a physiotherapist when required. Referrals can be made to a dietitian, older persons mental health nurse specialist, speech language therapist and a wound care specialist nurse is available as required through the local DHB. There was evidence in two resident files of involvement of the older persons mental health clinical nurse specialist.<br><br>Care staff interviewed could describe a verbal and written handover at the beginning of each duty that maintains a continuity of service delivery and this was sighted on the day of audit. Care staff documents progress notes at least daily, however, registered nurse entries in progress notes have not always occurred as required or indicated following an incident or changes in health status.<br><br>Residents interviewed reported their needs and expectations were being met. When a resident's condition alters, the general manager or casual RN initiates a review with a GP. The incident forms did not always provide evidence of whānau notifications or reason for not following incidents (link 1.6.3). Progress notes reviewed did not always provide evidence that whānau have been notified of changes to health including infections, GP visits, medication changes and any changes to health status. On interview, family members confirmed they were kept informed of matters relating to changes in health including the recent Covid outbreak.<br><br>Two wound assessments and wound management plans were reviewed for current skin tears. Both wounds were improving, and evidenced assessments and plans completed as scheduled. The service does not document a wound register; however, the RN had a good knowledge of both current wounds. There is access to wound expertise from a wound nurse specialist from the local DHB. |

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| | | Caregivers interviewed stated there are adequate clinical supplies and equipment provided including continence, wound care supplies and pressure injury prevention resources. There is access to a continence specialist as required.<br><br>Care plans do not always reflect management of medical conditions, for example shortness of breath and diabetes. Care staff complete monitoring charts including bowel chart, blood pressure and blood sugar levels, however monitoring charts have not always been completed as scheduled. Neurological observations have not always been completed for unwitnessed falls.<br><br>Written evaluations reviewed identified if the resident goals had been met or unmet. Short-term care plans (STCPs) have been utilised for issues such as infections and weight loss, however open short term care plans (STCPs) have not always been maintained or evaluated in a timely manner . |
| Subsection 3.3: Individualised activities<br><br>The people: I participate in what matters to me in a way that I like.<br><br>Te Tiriti: Service providers support Māori community initiatives and activities that promote whanaungatanga.<br><br>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. | FA | There is a qualified diversional therapist (DT) who works Monday to Wednesday from 10 am to 3 pm and an activities co-ordinator (AC) who works Thursday and Friday from 9 am to 3 pm. On Fridays, the AC has a dual role with responsibility for personal laundry. The overall programme has integrated activities that is appropriate for the cohort of residents. The daily programme is written on the whiteboard in the dining room. Activities include exercises or a walk, quoits, bowls and other indoor physical activities, bingo, quizzes, newspaper reading, word games, board games, craft, shopping trips and van outings, and seasonal celebrations. The programme allows for flexibility and resident choice of activity. The residents assessed at rest home level in the serviced apartments are included and attend activities in the care facility. Community visitors include entertainers, and church services when Covid restrictions allow. Residents are encouraged to maintain links to the community such as the talk and tea meetings run by age concern.<br><br>The service is working towards ensuring that their staff support future Māori residents in meeting their health needs and aspirations in the community and are looking at options to increase opportunities |

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| | | towards facilitating Māori to participate in te ao Māori. The Māori Health plan will be updated to incorporate this for when they have Māori residents. The service is planning to celebrate Māori specific cultural days.<br><br>There is a large lounge and separate dining room where group activities can occur. One-on-one activities such as individual walks, chats and hand massage/pampering occur for residents who are unable to participate in activities or choose not to be involved in group activities.<br><br>A resident lifestyle profile and activity assessment informs the activities plan. Individual activities plans were seen in resident files reviewed. The diversional therapist completes monthly progress notes and six-monthly evaluations. The service receives feedback and suggestions for the programme through three monthly resident meetings and resident surveys (link 2.2.3). The residents interviewed were happy with the variety of activities provided. |
| Subsection 3.4: My medication<br><br>The people: I receive my medication and blood products in a safe and timely manner.<br><br>Te Tiriti: Service providers shall support and advocate for Māori to access appropriate medication and blood products.<br><br>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. | PA Moderate | There are policies and procedures in place for safe medicine management, however the policy related to safe storage could not be located (link 2.2.3). Medications are stored in a locked filing cabinet or in a medication trolley in an alcove located near to the GM's office. On the day of audit, the medication trolley was found to have a broken lock with two topical medications in it at the time.<br><br>Caregivers are responsible for administration of medication. All current caregiver's annually complete medication competencies and Medimap/medication training (sighted in staff files). Regular medications are administered from blister packs and 'as required' medications are delivered in blister packs. The GM checks the packs against the electronic medication chart and a record of medication reconciliation is maintained. Any discrepancies are fed back to the supplying pharmacy (also available on call). Expired medications are documented on a medication return form and returned to pharmacy weekly. Caregivers advised there was one self-medicating resident on the day of audit however the resident did not have a current competency. Caregivers administer regular controlled drugs. |

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| | | Controlled medication checks have not been consistently checked as required. A six-monthly reconciliation is completed. Care staff interviewed confirmed that the general manager will come in after hours to assist with clinical assessments including pain assessments for the administration of 'as required' controlled drug administration.<br><br>The temperatures of the medication fridge located the RN office are checked at least weekly and recorded. On the day of audit, the fridge stored insulin only. Temperatures had not always been maintained within the acceptable temperature range and there was no evidence of corrective actions implemented following the deficits.<br><br>The temperature of the alcove area is not monitored. Eye drops were dated on opening and were noted to be current. Twelve electronic medication charts were reviewed and met prescribing requirements. Not all medication charts had photo identification and allergy status noted. One of the services GPs had reviewed the medication charts three-monthly as required however not all residents from other GPs evidenced reviews has occurred three-monthly. Discussion and consultation with residents and or whānau member takes place during these reviews. The effectiveness of 'as required' medication had been documented in the medication system.<br><br>Standing orders are not in use. All medications are charted either regular doses or as required. Over the counter medications are not always prescribed on the electronic medication system.<br><br>There was no documented evidence of outcomes of medication internal audits (link 2.2.3). The service is working towards involvement of future Māori residents in regard to medication management |
| Subsection 3.5: Nutrition to support wellbeing<br><br>The people: Service providers meet my nutritional needs and consider my food preferences.<br><br>Te Tiriti: Menu development respects and supports cultural beliefs, values, and protocols around food and access to | PA Moderate | The food services are overseen by a newly employed qualified chef. All meals and baking are prepared and cooked on site. The chef has completed food safety training and staff are trained in food safety at orientation and received annual food service training. The four-week summer menu has been reviewed by a registered dietitian in November 2021. The 4-week winter menu is due for review. The service is working towards how they can incorporate Māori residents' |

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| traditional foods.<br><br>As service providers: We ensure people's nutrition and hydration needs are met to promote and maintain their health and wellbeing. | | cultural values and beliefs into menu development and food service provision. A dietary profile is completed by a RN and sent to the kitchen. The information in the kitchen folder does not always reflect the profile in the resident's individual file. Dislikes and special dietary requirements are accommodated including food allergies. On the day of the audit, it was difficult to readily identify individual residents' preferences and special diets. The service caters for residents who require texture modified diets and other foods. The kitchen is adjacent to the main dining room and meals are plated in the kitchen and served directly to residents in the dining room or individually plated and taken on a trolley to the residents' rooms. On the day of the audit, it was noted four meals on a trolley due for delivery to the rooms in the care facility were not covered.<br><br>Residents in the serviced apartments enjoy their meals in the dining room in the village communal area. Food is transported in a hotbox and served directly from the kitchenette in the dining room.<br><br>Residents may choose to have meals in their rooms. The food control plan is current and due to expire 30 June 2023. Temperature checks are not consistently recorded for, inward goods, end-cooked foods, reheating (as required), and serving temperatures. Fridge and freezer temperatures were recorded however frequencies are inconsistent and are not recorded in weekends. Resident preferences are considered with menu reviews. Residents interviewed expressed their satisfaction with the meal service. Perishable foods and dry goods in original packaging were date labelled. There is partial decanting of dry goods. Not all decanted foods were dated. Cleaning schedules are documented but not consistently maintained, and fly screens were positioned on doors and windows however were not clean, or in good repair (link 5.5.3). Staff were observed to be wearing appropriate personal protective clothing. Chemicals were stored safely. Chemical use and dishwasher efficiency is monitored. Residents provide verbal feedback on the meals through the three-monthly resident meetings.<br><br>Residents are weighed monthly unless this has been requested more frequently due to weight loss. This is recorded in the medication management system and is graphed. The long-term care plan section |

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| | | for nutritional needs identifies food and fluid texture requirements, allergies, and any swallowing difficulties. These sections were completed in the six resident files reviewed. The resident files reviewed demonstrated that residents were maintaining their weights.<br><br>There is a specific policy that documents the dos and don'ts in respect of food services and include the key concepts of tapu and noa that are consistent with logical Māori view. |
| Subsection 3.6: Transition, transfer, and discharge<br><br>The people: I work together with my service provider so they know what matters to me, and we can decide what best supports my wellbeing when I leave the service.<br><br>Te Tiriti: Service providers advocate for Māori to ensure they and whānau receive the necessary support during their transition, transfer, and discharge.<br><br>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. | FA | Planned exits, discharges or transfers were coordinated in collaboration with the resident and whānau to ensure continuity of care. There were documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. The residents and their families were involved for all exits or discharges to and from the service. Residents and whānau are advised options to access other health and disability services on request.<br><br>There was evidence on file of transfer documentation for one resident sent to hospital and included a resident profile including contact details of next of kin, resuscitation status and medication chart. One resident file reviewed of a resident returning from hospital with changes in mobility and pain did not evidence all of the recommendations and follow up listed on the discharge notes (link progress 3.2.5). |
| Subsection 4.1: The facility<br><br>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.<br><br>Te Tiriti: The environment and setting are designed to be Māori-centred and culturally safe for Māori and whānau.<br><br>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 | FA | The building holds a current warrant of fitness which expires 17 May 2022. The maintenance (handy man)/laundry person works Monday to Thursday from 8 am to 1 pm. There is a maintenance request book for repair and maintenance requests located in the nurse's station. This is checked daily and signed off when repairs have been completed. There is an annual preventative maintenance plan initiated and implemented. The general manager interviewed stated carpets and drapes are being replaced in stages.<br><br>Hot water temperatures are checked by the maintenance person and recorded in the maintenance folder. Essential contractors/tradespeople are available 24 hours as required. A letter |

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| throughout. The physical environment optimises people's sense of belonging, independence, interaction, and function. | | from an external contractor (sighted) dated 28 March 2022 confirmed test and tag of electrical equipment was completed for all electrical equipment in the facility. Medical equipment, and scales were last calibrated in June 2021.<br><br>The maintenance role includes maintenance of the gardens and grounds. The corridors are suitable for safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. There is a wooden veranda with decking attached and surrounding the facility with seating and shade. There is safe access to all communal areas. Caregivers interviewed stated they have adequate equipment to safely deliver care for rest home residents.<br><br>There is a mix of resident rooms with shared ensuites with privacy locks and all other rooms have hand basin ensuites. There are communal bathrooms/showers located close to the resident rooms within the facility with privacy signage. Fixtures, fittings, and flooring are appropriate. Toilet/shower facilities are easy to clean. There is sufficient space in toilet and shower areas to accommodate shower chairs and commodes. There are sufficient communal toilets situated in the vicinity of the lounge and dining room. A toilet near the main lounge is available for visitors. Studio rooms are located within the same building however there is no internal access between the two areas. There is an external entrance located in close proximity to the rest home entrance.<br><br>Studio rooms all have ensuites and are spacious enough to accommodate mobility equipment and provide safe cares. Studio rooms have safe access to an external area, and an internal door opens into a hallway leading to a communal area and dining room. Studio rooms have sufficient natural light, heating (heat pumps) and ventilation. There is a safe level walkway between the village and rest home.<br><br>There is sufficient space in all areas to allow care to be provided and for the safe use of mobility equipment. Caregivers interviewed reported that they have adequate space to provide care to residents. |

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| | | Residents are encouraged to personalise their bedrooms as viewed on the day of audit.<br><br>The dining room is adjacent to the kitchen and open plan with doors that open out to an outdoor deck with raised gardens. There is a main lounge and a smaller seating alcove throughout the facility. There is safe access to the decking areas and gardens. All communal areas are easily accessible for residents with mobility aids with ramp access. All bedrooms and communal areas have sufficient natural light and ventilation.<br><br>There is electric wall heating in resident rooms, corridors and bathrooms and heat pumps in communal areas.<br><br>The service is not planning any major refurbishments or building projects; however, the service is open to consider how designs and environments reflect the aspirations and identity of Māori. |
| Subsection 4.2: Security of people and workforce<br><br>The people: I trust that if there is an emergency, my service provider will ensure I am safe.<br><br>Te Tiriti: Service providers provide quality information on emergency and security arrangements to Māori and whānau.<br><br>As service providers: We deliver care and support in a planned and safe way, including during an emergency or unexpected event. | PA Moderate | Emergency management policies, including the pandemic plan, outlines the specific emergency response and evacuation requirements as well as the duties/responsibilities of staff in the event of an emergency. Emergency management procedures guide staff to complete a safe and timely evacuation of the facility in the case of an emergency. Emergency flip charts and up to date resident evacuation lists are available.<br><br>A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. A fire evacuation drill is repeated six-monthly in accordance with the facility's building warrant of fitness. The last drill took place on November 2021. An external certified contractor completes annual checks of the fire extinguishers, sprinklers and smoke alarms and fire hoses.<br><br>There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Civil defence supplies are stored in a cabinet located in the rest home foyer with a monthly check list of contents attached to the front of the cabinet, however the checks had not been implemented. On the day of audit, |

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| | | a number of leaking batteries were identified. Sufficient water is stored in 20 litre containers in an external shed and a water tank to provide residents and staff with three litres per day for a minimum of three days. Emergency management is included in staff orientation and external contractor orientation. It is also ongoing as part of the education plan and was last held in November 2021. The general manager, casual RN, eleven caregivers and DT (also the dedicated van driver) are first aid qualified (current certificates). A minimum of one person trained in first aid is available at all times.<br><br>There are call bells in the residents' rooms, studio rooms and ensuites, communal toilets and lounge/dining room areas. Indicator lights are displayed above resident doors to alert them of who requires assistance. Staff are also alerted by pocket pagers and display screens. Residents were observed to have their call bells in close proximity when in their room. Residents interviewed confirmed that call bells are answered in a timely manner. The building is secure after hours, there is also a security contractor that visits during the night and staff complete security checks. |
| Subsection 5.1: Governance<br><br>The people: I trust the service provider shows competent leadership to manage my risk of infection and use antimicrobials appropriately.<br><br>Te Tiriti: Monitoring of equity for Māori is an important component of IP and AMS programme governance.<br><br>As service providers: Our governance is accountable for ensuring the IP and AMS needs of our service are being met, and we participate in national and regional IP and AMS programmes and respond to relevant issues of national and regional concern. | PA Moderate | The owner is having regular meetings with the general manager and is informed of infection data through a monthly report. The team discusses current infection concerns at combined staff meetings (meeting minutes sighted) however Covid-19/pandemic planning was not always discussed as part of the meeting minutes. The infection prevention plan is developed by an external consultant and collated data is reviewed against this.<br><br>The general manager oversees infection control and prevention across the service. The job description outlines the responsibility of the role. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. Infection control is linked into the quality risk and incident reporting system. Infection control audits are scheduled annually.<br><br>The service has access to an infection prevention clinical nurse specialist from the local DHB. The DHB nurse specialist has had |

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| | | input into the facilities infection preparedness review.<br><br>The facility had a recent Covid-19 outbreak and was actively working with the DHB to support them through processes.<br><br>There was no continuous risk assessment completed for entry to the facility for visitors/contractors under the Covid-19 orange traffic light protection framework and MOH guidelines for ARRC facilities.<br><br>Staff and visitors wear masks and visitors sign in a visitors' book.<br><br>There are hand sanitisers strategically placed around the facility. Residents and staff are offered influenza vaccinations and all residents are fully vaccinated against Covid-19. Flu vaccinations are booked for 11 May 2022. There were no residents with Covid-19 infections on the days of audit. |
| Subsection 5.2: The infection prevention programme and implementation<br><br>The people: I trust my provider is committed to implementing policies, systems, and processes to manage my risk of infection.<br><br>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.<br><br>As service providers: We develop and implement an infection prevention programme that is appropriate to the needs, size, and scope of our services. | FA | The general manager (RN) has responsibility for infection control prevention and coordination. The general manager is supported by the DHB nurse specialist, caregivers and general practitioners who can provide input when requested.<br><br>The general manager is liaising with the DHB and the GP regarding procurement processes or equipment, devices, and consumables used in the delivery of health care. The service is using the Ministry of Health portal to order consumable personal protective clothing. During Covid-19 lockdown there were regular zoom meetings with the DHB Aged Residential Care CNS which provided a forum for discussion and support for facilities. The service has a Covid-19 response plan (Outbreak pandemic management plan and prevention plan) developed by an external provider which includes preparation and planning for the management of lockdown, communication channels, screening, transfers into the facility and notification of positive tests should this occur. There are outbreak kits readily available and sufficient additional supplies are stored in a personal protective equipment cupboard and throughout the facility. IP, outbreak prevention and management related policies are available to |

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| | | staff in a pandemic folder.<br><br>The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. Annual review of the infection prevention programme has been completed for 2021, surveillance and meeting minutes sighted (link 2.2.3).<br><br>There were handbasins available for staff to wash hands with flowing soap and hand towels available. Staff were observed to perform good hand hygiene.<br><br>There are policies and procedures in place around reusable and single use equipment. All shared equipment is appropriately disinfected between use. The external contractor responsible for policy development is working towards incorporating te reo Māori information around infection control for Māori residents and encouraging culturally safe practices acknowledging the spirit of Te Tiriti. There are no plans to change the current environment, however, the service will consult with the infection control coordinator if this occurs. The external consultant provided updated audit tools to safely assess and evidence that these procedures are carried out. The new developed policies include participation in partnership with Māori for the protection of culturally safe practice in IP and acknowledge the spirit of Te Tiriti. |
| Subsection 5.3: Antimicrobial stewardship (AMS) programme and implementation<br><br>The people: I trust that my service provider is committed to responsible antimicrobial use.<br><br>Te Tiriti: The antimicrobial stewardship programme is culturally safe and easy to access, and messages are clear and relevant.<br><br>As service providers: We promote responsible antimicrobials prescribing and implement an AMS programme that is appropriate | FA | The service has an anti-microbial use policy and procedures which have been developed by an external consultant and is appropriate for the size and scope of the service. The antimicrobial stewardship policy aims to a) reduce antimicrobial resistance, b) improve residents' outcomes and safety, c) ensure cost effective therapy, d) identify the prevalence of antimicrobial resistance. The policy indicates annual review of the existing infection prevention and control programme to include all components of an antimicrobial stewardship programme (i) leadership commitment, accountability and expert buy-in (GP and pharmacist) (ii) multidisciplinary approach to coordinate |

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| to the needs, size, and scope of our services. | | interventions including goal setting, tracking, reporting and education.<br><br>The registered nurses (general manager and casual RN) ensure the timely and accurate assessment and reporting of infections and liaise with the GP to access appropriate treatment.<br><br>Each infection must meet specific criteria. The GPs are responsible for the diagnosis and treatment and the RNs are responsible for ensuring the optimal treatment is provided, and to be accurately documented in the resident's clinical file.<br><br>All infections are logged on an incident form, and a short-term care plan is implemented (link 3.2.1). These are collated monthly, fully analysed, and discussed at meetings. The infection control nurse collates data around the type of infection, type of antimicrobial used and the duration of the treatment. Antibiotic and antimicrobial use is recorded in medication records and medical notes. Monthly infection rates are reviewed monthly and reported in meetings. |
| Subsection 5.4: Surveillance of health care-associated infection (HAI)<br><br>The people: My health and progress are monitored as part of the surveillance programme.<br><br>Te Tiriti: Surveillance is culturally safe and monitored by ethnicity.<br><br>As service providers: We carry out surveillance of HAIs and multi-drug-resistant organisms in accordance with national and regional surveillance programmes, agreed objectives, priorities, and methods specified in the infection prevention programme, and with an equity focus. | PA Low | Infection surveillance is an integral part of the infection control programme and is described in Wensley House's policies and procedures. The surveillance activities undertaken is appropriate for the size , type of service and acuity of the residents in care. Surveillance activities occur by collating and analyse data manually, issues/trends are identified investigated. Ethnicity data is collated during admission processes, however, not yet captured around infections.<br><br>The general manager will raise and report issues of concern with the owner.<br><br>Monthly infection data is collected for infections based on signs, symptoms, and definition of infection, however, not all recent infections are entered into the infection register. Surveillance of all infections (including organisms where known) is entered onto a monthly infection summary. The general manager collates monthly infection surveillance. This information is discussed at two to three monthly management meetings and concerns are discussed at staff |

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| | | meetings. The service receives email notifications and alerts from the DHB for any community concerns. There was a Covid-19 outbreak in March 2022. Eighteen staff and 26 residents were found to be Covid-19 positive.<br><br>There were no residents with Covid on the day of the audit. There have been no other outbreaks since the previous audit.<br><br>The audit was conducted in the orange traffic light system. |
| Subsection 5.5: Environment<br><br>The people: I trust health care and support workers to maintain a hygienic environment. My feedback is sought on cleanliness within the environment.<br><br>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.<br><br>As service providers: We deliver services in a clean, hygienic environment that facilitates the prevention of infection and transmission of antimicrobial resistant organisms. | PA Moderate | There are policies around waste management. Management of waste and hazardous substances is covered during orientation of new staff and is included as part of the annual training plan. There is a waste disposal policy and an updated disinfection and sterilisation policy.<br><br>Material safety datasheets are available in the three laundries and in and cleaners' cupboard. Personal protective equipment including gloves, aprons and eyewear are available for staff throughout facility. There is a locked cleaner's cupboard and safe storage of chemicals. The cleaner's trolley is locked in the cupboard when not in use.<br><br>Infection control policies state specific tasks and duties for which protective equipment is to be worn.<br><br>There are laundry and cleaning policies and procedures. Laundry services is available Monday to Fridays. There is plenty of linen stock available for weekends. There is a defined dirty to clean flow in each (three) laundry. One main laundry is for linen only and the other two (one for rest home and one for studio rooms) for personal laundry. Two cleaners (one a contactor cleaner) interviewed were knowledgeable around infection control practise and management of infectious laundry.<br><br>All chemicals on the cleaner's trolley were labelled and in original containers. One cleaner was observed using best practice including the use of colour coded cloths and mops. There is an internal audit around laundry services and environmental cleaning completed as part of the internal audit schedule. Staff have completed chemical |

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| | | safety training. |
| Subsection 6.1: A process of restraint<br><br>The people: I trust the service provider is committed to improving policies, systems, and processes to ensure I am free from restrictions.<br><br>Te Tiriti: Service providers work in partnership with Māori to ensure services are mana enhancing and use least restrictive practices.<br><br>As service providers: We demonstrate the rationale for the use of restraint in the context of aiming for elimination. | FA | Restraint policy confirms that restraint consideration and application must be done in partnership with families, and the choice of device must be the least restrictive possible. At all times when restraint is considered, the facility will work in partnership with Māori, to promote and ensure services are mana enhancing. At the time of the audit, the facility was restraint-free.<br><br>The facility, led by the general manager, is committed to providing services to residents without use of restraint. Restraint is an agenda item in meeting minutes and (if any) would be reported in the monthly staff/quality meetings.<br><br>Maintaining a restraint-free environment is included as part of the mandatory training plan and orientation programme and have been completed in 2021. |

# 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) |
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| Criterion 1.6.3<br>My service provider shall practise open communication with me. | PA Low | Residents interviewed stated they can raise concerns with staff or through their regular resident meetings. Relatives stated the general manager communicates through emails and will inform them of any changes to their relative`s health or general issues pertaining Wensley house. Incident forms are used for documenting adverse event forms and a section to indicate if next of kin was contacted (or not), these sections were not always completed. | Five of ten incident report forms did not evidence next of kin (or reason for not) informed following an adverse events. | Ensure all communication with families is documented in resident files.<br><br>90 days |
| Criterion 1.8.2<br>I shall be informed about and have easy access to a fair and responsive complaints | PA Moderate | Residents received information regarding the complaints process at admission. On the day of the audit there were no complaint forms or information regarding the Nationwide | (i) Not all complaints received were filed in the folder and/or recorded in the register.<br>(ii) Complaint forms were available | (i) Ensure all complaints are recorded in the complaints register/folder.<br>(ii) Ensure complaints forms are |

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| process that is sensitive to, and respects, my values and beliefs. | | Health and Disability Advocacy Service (pamphlets) available on display in common areas or at the entrance of the facility. Caregivers interviewed confirmed the forms to be in a filing cabinet.<br><br>Written complaints are acknowledged; however, resolution letters do not have contact details of the Nationwide Health and Disability Advocacy Service provided to any complainants. Verbal complaints are noted in the meeting minutes but not recorded in the register. It was unsure what the process (responsibilities and follow-up process) is to address verbal complaints. Not all complaints received were recorded in the complaints register. Staff completed training/education in complaints management in 2021. | but not accessible.<br><br>(iii) Pamphlets and information related to the Nationwide Health and Disability Advocacy Service information were not available/accessible to residents/whānau.<br><br>(iv) No resolution letters evidence that contact details of Nationwide Health and Disability Advocacy Service is provided to all complainants.<br><br>(iv) There was no clear process of addressing verbal complaints. | easily accessible.<br><br>(iii-iv) Ensure information regarding independent support and access to the Nationwide Health and Disability Advocacy Service is available and ensure a clear process (responsibilities) of addressing/response to verbal complaints.<br><br>(v) Ensure a clear process of addressing verbal complaints.<br><br>60 days |
| Criterion 2.1.2<br><br>Governance bodies shall ensure service providers' structure, purpose, values, scope, direction, performance, and goals are clearly identified, monitored, reviewed, and evaluated at defined intervals. | PA Low | Business goals are defined in the business plan but there was no evidence to indicate that goals are regularly reviewed. | There is a lack of documented evidence to indicate that business goals are regularly monitored, reviewed, and evaluated at defined intervals. | Ensure that the business goals are monitored, reviewed, and evaluated at defined intervals.<br><br>90 days |
| Criterion 2.2.3 | PA | The general manager stated the quality objectives for 2021 and 2022 to be zero | (i). Quality objectives were not recorded, and progress was not | (i). Ensure quality objectives are recorded and progress is |

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| Service providers shall evaluate progress against quality outcomes. | Moderate | medication errors and continue to reduce falls by an individual approach, however, these were not recorded, and progress was not evidenced as measured. Analysis of clinical data and trends (graphs sighted) evidenced that these goals are met.<br><br>Policies are reviewed by an external consultant and new policies are sent by email to the general manager to include site-specific information and to be dated and uploaded to the system. A full documentation review could not be completed prior to the audit as policies were not readily available and some policies were last uploaded in 2013. None of the policies received were dated. Policies were in folders and/or electronic format. On the day of the audit documents/policies were requested but could not be easily located. Meeting minutes evidenced new policies were mentioned in meeting minutes till March 2021, however, there is no further evidence new policies has been discussed since.<br><br>The internal audit schedule in the business plan stated the following audits (not limited to) to be completed annually: admission documentation, care planning, cleaning audits, Code of Rights, complaints, cultural and spiritual service, emergency and security, environmental and health and safety, food satisfaction survey, food services, handwashing and infection control, incidents and accidents, hazard reporting, medication management, | evidenced as measured for 2021/2022.<br><br>(ii). Policies were not a) kept centralised; b) dated when new version received; c) site specific and d) there was no documented evidence that staff are aware of new policies.<br><br>(iii). Analysis and recommendations/corrective actions to correct identified gaps including surveys and internal audits were not documented and files in the audit/survey folder.<br><br>(iv). Internal audit/survey outcomes are not a standardised topic in meeting minutes. | measures at regular intervals.<br><br>(ii) Ensure to enforce a document management control system that includes issuance, distribution, and accessibility of documents.<br><br>(iii) Ensure analysis and recommendations/corrective actions to correct any identified gaps including surveys and audits are documented and filed in the audit/survey folder.<br><br>(iv) Ensure all internal audit outcomes are discussed during relevant meetings.<br><br>90 days |

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| | | pain management, privacy of information, satisfaction survey and wound management. Audit outcomes are not a standardised topic on the meeting's agenda. Internal audits have been completed and signed off for 2021 on the annual internal audit schedule document, however, the general manager could not locate the internal audit folder to evidence the outcomes/results of the internal audits.<br><br>The general manager reported that internal audits are a team responsibility. There was an internal audit schedule implemented and signed off for 2021 and being implemented and on schedule for 2022. Analysis and recommendations/corrective actions documented could not be located for 2021, however these were in place for 2022.<br><br>The resident satisfaction and food survey was signed off as completed on the internal audit schedule for June 2021, however an analysis and recommendations were not documented | | |
| Criterion 2.3.4<br><br>Service providers shall ensure there is a system to identify, plan, facilitate, and record ongoing learning and | PA Low | Ten of fourteen caregivers are working at a skill level 4 with a Careerforce qualification. Staff interview and observation evidenced staff to be knowledgeable regarding clinical and non-clinical issues related to the residents under their care. Education sessions have been held around | (i) There is no formal in-service education planner documented for 2021/2022.<br><br>(ii) There was no evidence documented to include the content of training sessions.<br><br>(iii) There was no evidence of falls | (i) Ensure there is a formal schedule/planner for in-service training.<br><br>(ii) Ensure a brief content/description of training/education sessions delivered to/undertaken by staff will |

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| development for health care and support workers so that they can provide high-quality safe services. | | EPOA, advance directives, first aid, medication management, pressure care and wound training, mouth and dental cares, fire safety including emergency management, health, and safety, Code of conduct, Code of Rights includes informed consent abuse and neglect, sexuality and intimacy, chemical safety, manual handling, food safety, infection control, restraint minimisation and cultural safety. Caregivers reported they each had three one-on-one sessions in the use of PPE, training in pandemic planning/management and complaints management, this was recorded in their individual files. However, there was no annual planner for a service education plan available for 2021 and 2022 that documents the facility specific requirements that is responsive to the needs of people across the service and frequencies. Content of sessions were not documented.<br><br>There was evidence of external trainers used to facilitate some sessions. | prevention, continence, training for 2021 and 2022. | be documented.<br><br>(iii) Ensure to provide/include training specific to the specific needs of the residents at Wensley House.<br><br>90 days |
| Criterion 3.2.1<br><br>Service providers shall engage with people receiving services to assess and develop their individual care or support plan in a timely manner. Whānau shall be | PA Moderate | Initial interRAI assessments have been completed within the required timeframes for three rest home residents. Initial assessments and care plans have been developed within the required timeframes for two of the six files reviewed. It was not possible to review initial assessment and initial care plan dates for three files as notes had been archived, requested but not | (i) Initial assessments and initial care plans within required timeframes were not evidenced for three residents.<br><br>(ii). Five of six resident care plans reviewed did not evidence resident or family input to care. | (i) Ensure initial assessments and care plans are completed with required timeframes.<br><br>(ii) Ensure care plans reflect input from residents and their identified family/whanau |

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| involved when the person receiving services requests this. | | provided. A sixth file evidenced recent initial assessments and care plan; however, these were not dated. Three of six resident files identified long term cares plans had been documented with 21 days of admission. Dietary profiles and nutritional assessments have been documented at the time of admission. On interview the GM stated a copy of the dietary profile is provided for kitchen staff. Care plans did not always evidence resident and/or next of kin involvement. | | 60 days |
| Criterion 3.2.5<br>Planned review of a person's care or support plan shall:<br>(a) Be undertaken at defined intervals in collaboration with the person and whānau, together with wider service providers;<br>(b) Include the use of a range of outcome measurements;<br>(c) Record the degree of achievement against the person's agreed goals and aspiration as well as whānau goals and aspirations;<br>(d) Identify changes to the person's care or support plan, which | PA Moderate | As per policy, the registered nurse is responsible for assessments and documentation of care plans. There was evidence of assessment updates and evaluations conducted for some residents with changes to care plans made during 2020 and early 2021. Re-assessments, care plan updates and review of residents' activity plans were evidenced to be inconsistent in 2020 and 2021. The casual RN (not interRAI trained) has recently reviewed all care plans and evaluations are current for all current residents. The GM has responsibility for updating all interRAI assessments and is actively involved in clinical care. Progress notes are maintained by the caregivers, but not always for the registered nurse. | (i) One resident who sustained a fracture did not evidence care to address changed mobility or pain management on return from hospital.<br>(ii) Progress notes and care plans do not always demonstrate RN input where required after a significant event or changes in health or weekly monitoring of care.<br>(iii). Five current short term care plans have not been reviewed when the short-term condition had resolved.<br>(iv) Care plan evaluations have not been completed within required timeframes for three of six resident files reviewed. | (i) Ensure that all acute changes to care requirements are documented in a short or the long-term care plan updated.<br>(ii) Ensure progress notes are reflective of timely RN input and next of kin involvement and notification.<br>(iii). Ensure short term care plans are evaluated at least weekly and either closed when resolved or transferred to the long-term care plan.<br>(iv) Ensure long term care plan evaluations are reviewed at least six-monthly<br>60 days |

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| are agreed collaboratively through the ongoing re-assessment and review process, and ensure changes are implemented;<br>(e) Ensure that, where progress is different from expected, the service provider in collaboration with the person receiving services and whānau responds by initiating changes to the care or support plan. | | | | |
| Criterion 3.4.1<br>A medication management system shall be implemented appropriate to the scope of the service. | PA Moderate | The service has policies in place which cover medication management however there is no policy provided in regard to safe storage. Medication errors are part of the quality indicator data and report at staff meetings. Caregivers are responsible for medication administration. Controlled medication stock checks are not always completed in accordance with medication legislation. The medication room and fridge temperatures are monitored weekly, however where temperatures are recorded outside the expected ranges, there was no evidence of corrective actions. The medication trolley was not clean and could not be secured.<br>The facility uses an electronic | (i). Medication fridge and room temperatures recorded were not consistently recorded to be within required ranges, and where temperatures are outside range, corrective actions have not been implemented.<br>(ii). The trolley is broken and unable to be locked.<br>(iii). On the day of audit, the trolley was visibly soiled.<br>(iv). Controlled drugs have not been consistently checked weekly in the register.<br>(v) Three residents did not have photos evident on medication | (i)-(iii). Ensure a policy on safe medication storage is available and implemented. -<br>(iv). Ensure weekly controlled medication checks are completed.<br>(v)-(vi) Ensure all resident medication charts evidence current photos<br><br>30 days |

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| | | medication system which alerts users to the requirement to update resident photos. With the exception of three residents admitted this year, all residents have a photo attached to their medication charts. Photos have not been reviewed since first uploaded. This was corrected the next day | charts.<br>(vi) Resident photos on medication charts have not been reviewed since first transferring to the system at least two years ago or since admission | |
| Criterion 3.4.2<br>The following aspects of the system shall be performed and communicated to people by registered health professionals operating within their role and scope of practice: prescribing, dispensing, reconciliation, and review. | PA Moderate | Medications have been prescribed by a GP excluding over the counter medications. The medication policy related to safe storage could not be located states all medication charts are reviewed at least three-monthly. One of the three GPs involved in resident care consistently reviews medications at least three-monthly. | Two of the services contracted GPs have not always reviewed resident medication charts three monthly. | Ensure all residents' medication charts are reviewed at least three-monthly.<br><br>30 days |
| Criterion 3.4.4<br>A process shall be implemented to identify, record, and communicate people's medicinerelated allergies or sensitivities and respond appropriately to adverse events. | PA Moderate | Medication errors are recorded on adverse event forms and reported in meeting minutes. Nine of twelve medication charts reviewed recorded the allergies and sensitives or nil known. These were corrected on the second day of the audit. | Three of twelve medication charts reviewed did not have allergies or nil known recorded. | Ensure all medication charts reflect the resident's allergy status.<br><br>60 days |
| Criterion 3.4.6 | PA | Medication management policies include a resident self-medication policy | The self-medicating resident's last competency review was | Ensure all self-medicating residents have a competency |

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| Service providers shall facilitate safe self-administration of medication where appropriate. | Moderate | and self-competency documents which states the resident will be assessed three-monthly by the GP. There is a process in place where caregivers monitor the resident taking medication as prescribed. On the day of the audit there was one resident self-administering medications. | undertaken over six months ago. | reviewed as per policy.<br><br>60 days |
| Criterion 3.5.3<br>Service providers shall ensure people's dining experience and environment is safe and pleasurable, maintains dignity and is appropriate to meet their needs and cultural preferences. | PA Moderate | There are polices in place to guide the nutritional well-being of residents. A recent food control plan documented verification for 18 months. Staff have received training in safe food management at orientation. | (i). Fridge and freezer temperatures have not been constantly documented.<br>(ii). Food temperatures have not been recorded consistently.<br>(iii). Plated meals delivered to rooms were not covered.<br>(iv). Decanted dry goods did not evidence expiry and/or decanting dates.<br>(v). Fridge contents were not consistently labelled and dated.<br>(vi). Eggs are routinely stored in the pantry.<br>(vii). Dietary profiles in the kitchen were not consistent with dietary profiles in the resident individual files. | (i)-(vi). Ensure the food control plan is implemented to include relevant temperature checks, food delivery and safe food storage.<br>vii). Ensure dietary profiles are current and updated as per policy.<br><br>60 days |
| Criterion 4.2.2<br>Service providers shall ensure there are implemented fire | PA Moderate | There are emergency flip charts throughout the facility and at the nurse's station. An up-to-date evacuation resident list is readily | (i) The emergency cupboard contents checklist has not been implemented.<br>(ii) On the day of audit two | (i) Ensure monthly emergency cupboard checks are implemented as per policy.<br>(ii) Ensure emergency cupboard |

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| safety and emergency management policies and procedures identifying and minimising related risk. | | available at the location of the flipcharts.<br><br>The emergency cupboard located in the foyer contains batteries, torches, paper plates, a transistor radio, hand sanitiser and other required items. A monthly checklist of contents is posted on the front of the cupboard. | packets of batteries were found to be leaking. | contents are removed and replaced when damaged or expired.<br><br>60 days |
| Criterion 5.1.4<br><br>Significant IP events shall be managed using a stepwise approach to risk management and receive the appropriate level of organisational support. | PA Moderate | The certification audit was conducted within the orange traffic light system. The pandemic plan is comprehensive and site-specific and covers requirements within the changes of the national Covid-19 prevention framework.<br><br>Regular visitors and contractors' vaccine passports are held in a file however visitors/contractors sign a visitors' book on entry but no health declaration. There was no signage at the door to prompt visitors/contractors to wear a mask, not visit when unwell/with symptoms or declare health in any form. Infection control meetings are part of the combined staff/quality and health and safety meetings, pandemic planning is an agenda item, however the content is very repetitive since October 2021 and does not include guidance and discussions around the changes in requirements under the Covid-19 protection framework. | (i) Risk measurements to control visitors were not appropriate within the orange traffic light Covid-19 protection framework.<br><br>(ii) Meeting minutes did not reflect detail provided to staff to guide them in the appropriate requirements of each step under the Covid-19 protection framework.<br><br>(iii) There was no debrief meeting following the Covid-19 outbreak in the facility. | (i)-(ii) Ensure all efforts are put in place to manage the risk of transmission and to ensure the safety of staff/residents and other.<br><br>(iii) Ensure a debrief meeting is held/lessons learned following the facility Covid-19 outbreak.<br><br>60 days |

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| Criterion 5.4.1<br>Surveillance activities shall be appropriate for the service provider and take into account the following:<br>(a) Size and complexity of the service;<br>(b) Type of services provided;<br>(c) Acuity, risk factors, and needs of the people receiving services;<br>(d) Health and safety risk to, and of, the workforce;<br>(e) Systemic risk to the health and disability system as a whole. | PA Low | There was a recent Covid-19 outbreak in the facility. The DHB worked closely with the facility to support them with processes after delay in notifications of one death and staff positive cases were noted. The resident files reviewed evidenced short term care plans for Covid-19, however the Covid-19 infections were not included as part of the outbreak in the surveillance data. | The residents affected by the outbreak were not included in the surveillance data for that month. | Ensure Covid-19 signs and symptoms and positive cases are included in the respiratory infection surveillance data.<br><br>90 days |
| Criterion 5.5.3<br>Service providers shall ensure that the environment is clean and there are safe and effective cleaning processes appropriate to the size and scope of the health and disability service that shall include:<br>(a) Methods, frequency, and | PA Moderate | There were monthly cleaning audits completed for 2022. There are cleaning schedules for all designated areas, however some of the cleaning was not maintained and flies could not be controlled. The general manager interviewed confirmed there is a monthly contractor that maintains the insect control dispensers. Another cleaning contractor maintains the high clean areas in the kitchen. | (i) There were bug, insect control & odour killer dispensers throughout the facility, however four did not work to control the flies.<br>(ii) The flyscreen in the kitchen was damaged and the windows greasy.<br>(iii) High clean on kitchen cupboards was not maintained. | (i)-(iii) Ensure to maintain cleaning and insect control.<br><br>60 days |

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| materials used for cleaning processes;<br>(b) Cleaning processes that are monitored for effectiveness and audit, and feedback on performance is provided to the cleaning team;<br>(c) Access to designated areas for the safe and hygienic storage of cleaning equipment and chemicals. This shall be reflected in a written policy. | | | | |

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

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

As above, criterion can be linked to the relevant subsection by looking at the code. For example, Criterion 1.1.1 relates to subsection 1.1: Pae ora healthy futures in Section 1: Our rights.

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

| No data to display |
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End of the report.