Edenvale Trust Board - Edenvale Rest Home

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 The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

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

The specifics of this audit included:

Legal entity:	Edenvale Trust Board
Premises audited:	Edenvale Rest Home
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 5 October 2022 End date: 6 October 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: 34

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All subsections applicable to this service 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
	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

Edenvale Rest Home provides rest home, hospital, and dementia level care for up to 45 residents. The service is owned and operated by a trust board and managed by a general manager and a clinical leader.

The general manager has experience and qualifications in operations management and has been in the role for four months. The GM is supported by the clinical leader who is a registered nurse and has been in the role for five years.

This certification audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members/ whānau, chairperson, managers, staff, and a general practitioner.

Strengths of the service include respect shown to the residents, a clean and tidy home-like environment, and a well-kept outdoors environment.

Improvements are required to internal auditing, reviewing resuscitation forms, and night shift registered nurse cover.

Ō tatou motika | Our rights

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

Edenvale Rest Home works collaboratively to support and encourage a Māori world view of health in service delivery. Māori will be provided with equitable and effective services based on Te Tiriti o Waitangi and the principles of mana motuhake.

The complaints process meets the requirement of the Code of Health and Disability Services Consumers' Rights.

Principles of mana motuhake were evidenced in service delivery. Pacific peoples are provided with services that recognise their worldviews and are culturally safe.

Residents and their family/whānau are informed of their rights according to the Code of Health and Disability Services Consumers' Rights (the Code). All staff receive in-service education on the Code.

Services provide support personal privacy, independence, individuality, and dignity. Staff interacted with residents in a respectful manner. The residents confirmed that they are treated with dignity and respect. There was no evidence of abuse, neglect, or discrimination.

Open communication between staff, residents, and families is promoted and was confirmed to be effective. Interpreter services are provided as needed. Family/whānau and legal representatives are involved in decision-making that complies with the law. Advance directives are followed wherever possible.

The residents' cultural, spiritual, and individual values and beliefs are assessed and acknowledged. The service works with other community health agencies, including external Māori cultural entities who are mana whenua.

Hunga mahi me te hanganga | Workforce and structure

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

The governing body assumes accountability for delivering a high-quality service. This includes supporting meaningful inclusion of Māori in governance groups, honouring Te Tiriti and reducing barriers to improve outcomes and achieving equity for Māori and people with disabilities.

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

The quality and risk management systems are focused on improving service delivery and care. Residents and families provide regular feedback and staff are involved in quality activities. An integrated approach includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Actual and potential risks are identified and mitigated.

Adverse events are documented with corrective actions implemented. The service complies with statutory and regulatory reporting obligations.

Staffing levels and skill mix meet the cultural and clinical needs of residents. Staff are appointed, orientated, and managed using current good practice. A systematic approach to identify and deliver ongoing learning supports safe equitable service delivery. At the time this audit was undertaken, there was a significant national health workforce shortage. Findings in this audit relating to staff shortages should be read in the context of this national issue.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people.

Ngā huarahi ki te oranga | Pathways to wellbeing

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

Residents are assessed before entry by the Needs Assessments and Service Coordination (NASC) team to confirm their level of care. The clinical leader (CL) and registered nurses (RNs) are responsible for the assessment, development, and evaluation of care plans. Care plans are individualised and based on the residents' assessed needs. Interventions were appropriate and evaluated in the care plans reviewed.

There are planned activities developed to address the needs and interests of the residents as individuals and in group settings. Activity plans are completed in consultation with family/whānau, residents, and staff. Twenty-four-hour activity care plans are in place. Residents and family/whānau expressed satisfaction with the activities programme.

The organisation uses an electronic medicine management system for e-prescribing, dispensing, and administration of medications. The general practitioner and nurse practitioner (GP/NP) are responsible for all medication reviews. Staff involved in medication administration are assessed as competent to do so.

The food service caters for residents' specific dietary likes and dislikes. Residents' nutritional requirements are met. Nutritional snacks are available for residents 24 hours a day.

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

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

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

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

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

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

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

The governing body ensures the safety of residents and staff through a planned infection prevention (IP) and antimicrobial stewardship (AMS) programme that is appropriate to the size and complexity of the service.

The service ensures the safety of residents and staff through a planned infection prevention (IP) and antimicrobial stewardship (AMS) programme that is appropriate to the size and complexity of the service. The clinical leader coordinates the programme.

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

Surveillance of health care associated infections is undertaken, and results shared with all staff. Follow-up action is taken as and when required. Outbreaks of COVID-19 have occurred since the previous audit, and these were well managed.

Here taratahi | Restraint and seclusion

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

The service aims for a restraint free environment. This is supported by the governing body and policies and procedures. There was one resident using a restraint at the time of audit. A comprehensive assessment, approval, monitoring process, with regular reviews occurs for any restraint used. Staff demonstrated a sound knowledge and understanding of providing the least restrictive practice, de-escalation techniques and alternative interventions.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Subsection	0	25	0	2	2	0	0
Criteria	0	158	0	2	2	0	0

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

Attainment against the Ngā Paerewa Health and Disability Services Standard

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

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

For more information on the standard, please click here.

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

Subsection with desired outcome	Attainment Rating	Audit Evidence
Subsection 1.1: Pae ora healthy futures Te Tiriti: Māori flourish and thrive in an environment that enables good health and wellbeing. As service providers: We work collaboratively to embrace, support, and encourage a Māori worldview of health and provide high-quality, equitable, and effective services for Māori framed by Te Tiriti o Waitangi.	FA	Edenvale Rest Home has developed policies, procedures and processes to embed and enact Te Tiriti o Waitangi in all aspects of its work. This is reflected in the values. The cultural policy describes tikanga, and guides staff in the delivery of services. Manu motuhake is respected. The general manager (GM) reported that if the resident preferred any homeopathic remedies their preferences would be respected and the general practitioner (GP) would be involved. Staff reported and records confirmed that staff have attended Te Tiriti o Waitangi training. Staff reported and meeting minutes evidenced that cultural events such as Matariki, Māori language week, and ANZAC day are celebrated. The GM and clinical leader (CL) reported that the Chaplin provides devotional services weekly. There are no staff or residents who identify as Māori.

		The general manager (GM) reported that the organisation intends to review the human resources policies and procedures position advertisement to include te reo in order to attract staff who identify as Māori. The GM reported that support would be provided in line with the resident's individual needs and the documented needs assessment. The family/whānau would be involved. The clinical leader (CL) reported that there had not been any Māori residents in the last 10 years. The GM reported that the provider intends to develop a Māori Health plan with input from cultural advisers.
Subsection 1.2: Ola manuia of Pacific peoples in Aotearoa The people: Pacific peoples in Aotearoa are entitled to live and enjoy good health and wellbeing. Te Tiriti: Pacific peoples acknowledge the mana whenua of Aotearoa as tuakana and commit to supporting them to achieve tino rangatiratanga. As service providers: We provide comprehensive and equitable health and disability services underpinned by Pacific worldviews and developed in collaboration with Pacific peoples for improved health outcomes.	FA	The GM reported that cultural and needs assessments would guide staff in the delivery of safe equitable services to Pasifika peoples. There are long serving staff who identify as Pasifika peoples who bring their own skills and expertise. The organisation intends on developing a Pasifika plan through liaison with Pasifika staff and the wider Pasifika community. Documentation sighted commits Edenvale to provide a culturally enhanced workforce that will respond effectively to the needs of the Pacific resident through training and cultural assessments. There are no residents who identify as Pacific peoples. The GM reported that the organisation intends to work with Pasifika communities, Health NZ and immigration services to improve outcomes.
Subsection 1.3: My rights during service delivery The People: My rights have meaningful effect through the actions and behaviours of others. Te Tiriti: Service providers recognise Māori mana motuhake (self-	FA	All staff interviewed at Edenvale Rest Home understood the requirements of the Code of Health and Disability Services Consumers' Rights (the Code) and were observed supporting residents following their wishes. Family/whānau and residents interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy

determination). As service providers: We provide services and support to people in a way that upholds their rights and complies with legal requirements.		Service) and confirmed they were provided with opportunities to discuss and clarify their rights. The Code is available in Māori and English languages. There were no residents and staff who identified as Māori on the audit days. The CL reported that the service will recognise Māori mana motuhake (self-determination) of residents, family/whānau, or their representatives by involving them in the assessment process to determine residents' wishes and support needs. There is a Cultural policy which outlines Tikanga best practice guidelines to follow.
Subsection 1.4: I am treated with respect The People: I can be who I am when I am treated with dignity and respect. Te Tiriti: Service providers commit to Māori mana motuhake. As service providers: We provide services and support to people in a way that is inclusive and respects their identity and their experiences.	FA	Residents are supported in a way that is inclusive and respects their identity and experiences. Family/whānau and residents, including people with disabilities, confirmed that they receive services in a manner that has regard for their dignity, gender, privacy, sexual orientation, spirituality, choices, and characteristics. Records sampled confirmed that each resident's individual cultural, religious, and social needs, values, and beliefs had been identified, documented, and incorporated into their care plan. The CL reported that residents are supported to maintain their independence by staff through daily activities. Residents were able to move freely within and outside the facility in the hospital and rest home wings. While residents in the dementia unit had access to walk freely in the secure spacious garden area. There is a documented privacy policy that references current legislation requirements. All residents have an individual room. Staff were observed to maintain privacy throughout the audit, including respecting residents' personal areas and by knocking on the doors before entering. All staff have completed cultural training as part of orientation and annually. The CL reported that Te reo Māori and tikanga Māori practices are promoted within the service through activities undertaken, such as policy reviews and translation of English words to Māori.

Subsection 1.5: I am protected from abuse The People: I feel safe and protected from abuse. Te Tiriti: Service providers provide culturally and clinically safe services for Māori, so they feel safe and are protected from abuse. As service providers: We ensure the people using our services are safe and protected from abuse.	FA	All staff understood the service's policy on abuse and neglect, including what to do should there be any signs. The induction process for staff includes education related to professional boundaries, expected behaviours, and the code of conduct. A code of conduct statement is included in the staff employment agreement. Residents reported that their property and finances are respected. Professional boundaries are maintained. The CL reported that staff are guided by the code of conduct to ensure the environment is safe and free from any form of institutional and systemic racism. Family/whānau members stated that residents were free from any type of discrimination, harassment, physical or sexual abuse or neglect and were safe. Policies and procedures, such as the harassment, discrimination, and bullying policy, are in place. The policy applies to all staff, contractors, visitors, and residents. The CL and GP stated that there have been no reported alleged episodes of abuse, neglect, or discrimination towards residents. There were no documented incidents of abuse or neglect in the records sampled. The Māori cultural policy in place identifies strengths-based, person-centred care and general healthy wellbeing outcomes for any Māori residents admitted to the service. This was further reiterated by the CL who reported that all outcomes are managed and documented in consultation with residents, enduring power of attorney (EPOA)/whānau/family and Māori health organisations and practitioners.
Subsection 1.6: Effective communication occurs The people: I feel listened to and that what I say is valued, and I feel that all information exchanged contributes to enhancing my wellbeing. Te Tiriti: Services are easy to access and navigate and give clear and relevant health messages to Māori. As service providers: We listen and respect the voices of the people who use our services and effectively communicate with	FA	Residents and whanau reported that communication was open and effective, and they felt listened to. EPOA/whānau/family stated they were kept well informed about any changes to their relative's health status and were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures. Personal, health, and medical information from other allied health care providers is collected to facilitate the effective care of residents. Each

them about their choices.		resident had a family or next of kin contact section in their file. There were no residents who required the services of an interpreter; however, the staff knew how to access interpreter services through Te Whatu Ora Te Toka Tumai Auckland if required. Staff can provide interpretation as and when needed and use family members as appropriate. The CL reported that any non-subsidised residents who are admitted to the service are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The CL reported that verbal and non-verbal communication cards, simple sign language, use of EPOA/whānau/family to translate and regular use of hearing aids by residents when required is encouraged.
Subsection 1.7: I am informed and able to make choices The people: I know I will be asked for my views. My choices will be respected when making decisions about my wellbeing. If my choices cannot be upheld, I will be provided with information that supports me to understand why. Te Tiriti: High-quality services are provided that are easy to access and navigate. Providers give clear and relevant messages so that individuals and whānau can effectively manage their own health, keep well, and live well. As service providers: We provide people using our services or their legal representatives with the information necessary to make informed decisions in accordance with their rights and their ability to exercise independence, choice, and control.	PA Low	The nursing team and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provided relevant guidance to staff. Residents' files sampled verified that informed consent for the provision of care had been gained appropriately using the organisation's standard consent form. These are signed by the enduring power of attorney (EPOA) and residents. Staff were observed to gain consent for day-to-day care, and they reported that they always check first if a consent form is signed before undertaking any of the actions that need consent. Interviews with relatives confirmed the service actively involves them in decisions that affect their family members' lives. All consent forms are signed and uploaded to the resident's electronic record management system. In interviews conducted with residents they reported that they felt safe, protected, listened to and happy with care/consent processes. The staff reported that, tikanga best practice guidelines in relation to consent during care was observed. Some of the sampled resuscitation authorisation forms were not reviewed annually as per organisational requirements.

Subsection 1.8: I have the right to complain The people: I feel it is easy to make a complaint. When I complain I am taken seriously and receive a timely response. Te Tiriti: Māori and whānau are at the centre of the health and disability system, as active partners in improving the system and their care and support. As service providers: We have a fair, transparent, and equitable system in place to easily receive and resolve or escalate complaints in a manner that leads to quality improvement.	FA	A fair, transparent, and equitable system is in place to receive and resolve complaints that leads to improvements. This meets the requirements of the Code. Residents and whānau understood their right to make a complaint and knew how to do so. Complaint forms and a box are in the lounge. The Code is available in te reo Māori and English. The GM is responsible for complaints management and follow up. The GM described the process should a complaint be received. Staff described the actions they would take should they receive a complaint. The complaints register evidenced there have been no complaints, including external complaints, received since 2020. The GM reported that the complaints policy and form will be updated to ensure the complaints process works equitably for Māori and that a translator and or an advocate who identified as Māori would be available to support people if needed.
Subsection 2.1: Governance The people: I trust the people governing the service to have the knowledge, integrity, and ability to empower the communities they serve. Te Tiriti: Honouring Te Tiriti, Māori participate in governance in partnership, experiencing meaningful inclusion on all governance bodies and having substantive input into organisational operational policies. As service providers: Our governance body is accountable for delivering a high-quality service that is responsive, inclusive, and	FA	The governing body assumes accountability for delivering a high-quality service through: • supporting meaningful inclusion/ representation of Māori in governance groups and honouring Te Tiriti. The chairperson reported that the board are extremely open to and intend to liaise with Māori representation. • defining a governance and leadership structure, including clinical governance, that is appropriate to the size and complexity of the organisation. The board of trustees made up of the chairperson, vice chair and four trustees meet six weekly. The chairperson and GM reported that the members bring professional skills to the role. The chairperson reported being on the board for 30 years, with 20 years

sensitive to the cultural diversity of communities we serve.		as chairperson. • appointing an experienced and suitably qualified person to manage the service. The service is managed by the GM who is has experience in operations management, has a Masters' degree in business administration and is a qualified Life Coach. The GM is supported by the CL who is a RN and the Office Administrator. • identifying the purpose, values, direction, scope and goals for the organisation, and monitoring and reviewing performance at planned intervals • demonstrating leadership and commitment to quality and risk management. The GM reported that board members provide advice and support as required between board meetings. • being focused on improving outcomes and achieving equity for Māori and people with disabilities. The CL reported that where staff need guidance, they have access to Te Whatu Ora Nurse specialist who comes each month to provide support with cultural needs. For example, staff were guided in providing support for a family/whānau. The chairperson reported that the provider intends to seek advice to strengthen the delivery of service to people with disabilities with input from through an external advisor. • identifying and working to address barriers to equitable service delivery. The GM reported that needs, behaviour and risk assessments, care planning, and training guides staff in the delivery of equitable care. Staff bring their skills and experience to the role. If a higher level of care is required, the resident is assessed for more support. A sample of board meeting minutes showed adequate information to monitor performance is reported. Topics included COVID-19, occupation level, staffing, residents and health and safety. The GM and the CL reported that clinical meetings are held monthly with the RNs, and TLs. The CL meets weekly with the nurse practitioner and

		GP to discuss resident's wellbeing. The GM confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency within the field. The GM attended the recent aged care association conference. When the GM is absent, the CL carries out all the required duties under delegated authority with support from the chairperson, and a board member with experience in human resources. The 2023 business plan is known as the Annual Plan on a Page. Our resources, Our Service, Our premises, Our people make up the four overarching themes. Each theme has goals including building on the workforce, performing staff surveys bi-annually, fostering a working environment and culture that staff are proud to be a part of, where sustainability and diversity matters. The plan was sighted. Residents receiving services and whānau participate in the planning, implementation, monitoring, and evaluation of service delivery through meetings and surveys. Resident meetings minutes include service satisfaction feedback and were sighted. The service holds age related contracts with Te Whatu Ora Te Toka Tumai Auckland for rest home, hospital, and dementia care for up to 45 residents. Four rooms allow for couples sharing a room. Contracts are also held with Manatū Hauroa for young people with a disability with long term chronic health needs (YPD). Thirty-four residents were receiving services under the contracts on the day of the audit. There were 11 rest home residents including one YPD resident. Fifteen hospital residents were receiving care. There were eight residents in the dementia wing at the time of audit. The maximum number is 12.

		Twenty-nine beds are certified as dual-purpose beds for rest home or hospital level care. The chairperson and the GM reported that Te Tiriti, health equity, and cultural safety training will be provided to the governance body.
Subsection 2.2: Quality and risk The people: I trust there are systems in place that keep me safe, are responsive, and are focused on improving my experience and outcomes of care. Te Tiriti: Service providers allocate appropriate resources to specifically address continuous quality improvement with a focus on achieving Māori health equity. As service providers: We have effective and organisation-wide governance systems in place relating to continuous quality improvement that take a risk-based approach, and these systems meet the needs of people using the services and our health care and support workers.	PA Low	The chairperson reported that the board of trustee's commitment to quality and risk is high. The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. The quality and risk management team is made up of the GM, CL, RNs, team leaders (TL), health and safety representative, and the activities co-ordinator. Meeting minutes were sighted. Discussions included COVID-19, and how the facility were responding to each wave of COVID-19. The GM reports to and attends the board meetings. Two GM reports were sighted and included resident feedback, staff training, reference to family and resident meetings. Residents, including YPD, whānau and staff contribution to quality improvement occurs through staff meetings, resident meetings, newsletters and compliments. The GM reported that the organisation plans to complete staff, resident and family/whānau surveys before the end of November. There was no current internal audit schedule in line with the requirement of the organisation's quality policy. There was no documented audit of cleaning, laundry, or infection control practice. This has resulted in a corrective action. The service has a culture of the principles of continuous quality improvement. For example, the GM recently purchased electronic devices for staff to use before or after their shifts to complete their online Careerforce modules. The GM reported that there are plans to provide training for staff so the quality of progress notes can improve to a higher standard. The plan was sighted.

		Policies reviewed covered all necessary aspects of the service and contractual requirements and those reviewed were current. Policies are held electronically, and staff have access to paper-based copies. The GM reported they are reviewed two yearly. Progress against quality outcomes is evaluated. The GM described the processes for the identification, documentation, monitoring, review and reporting of risks, including health and safety risks, and development of mitigation strategies. The register was current and was sighted. The chairperson reported that expert advice was provided through skilled board members. Staff document adverse and near miss events. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. The provider is not required to follow the National Adverse Event Reporting Policy. The GM and CL understood and has complied with essential notification reporting requirements. The GM reported that a S31 was completed when there was a change in the Facility Manager role. The CL reported that no notifications of significant events have been made to the Ministry of Health/ Te Whatu Ora since the previous audit. Twenty S31 notifications have been made relating to staff shortages since the last audit. The GM and CL reported that the provider is actively seeking to recruit RNs. There haven't been any police investigations, coroner's inquests, or issues-based audits and any other notifications. Service providers shall improve health equity through critical analysis of organisational practices. Data is gathered for example falls, skin tears, and bruises. Trends are graphed and were sighted. The CL reported that results are average. The GM discussed how the service

		intends to develop an internal benchmarking procedure to better measure relevant health performance indicators. The GM reported that staff will be able to deliver high quality health care for Māori through for example, training, including cultural safety training, and cultural assessments.
Subsection 2.3: Service management The people: Skilled, caring health care and support workers listen to me, provide personalised care, and treat me as a whole person. Te Tiriti: The delivery of high-quality health care that is culturally responsive to the needs and aspirations of Māori is achieved through the use of health equity and quality improvement tools. As service providers: We ensure our day-to-day operation is managed to deliver effective person-centred and whānau-centred services.	PA Moderate	There is a documented and implemented process for determining staffing levels and skill mixes to provide culturally and clinically safe care, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. A review of three weeks' rosters for the rest home, hospital and the dementia unit confirmed adequate staff cover is provided, with staff replaced in any unplanned absence. Five days a week, there is at least one RN in the hospital and rest-home on the morning and afternoon shifts between 8am and 11pm weekdays. There is no RN on site at night. An exemption has not been sought from Te Whatu Ora Te Toka Tumai Auckland. Three TLs have been appointed to mitigate the absence of an RN. Two TLs are nurses who are registered in their country of origin, but the registration is not recognized in New Zealand. Qualifications were sighted. One TL is a senior nurse aid with 30+ years' experience. A training package was developed for the TLs by the nurse educator who is an RN with a current practicing certificate. The RN has worked alongside the TLs for 18 months. One RN works 10am – 6.30pm or later if required. A TL covers the weekend RN vacancies. The TL has access to the CL who is On Call. Four nurse aids with a mix of long and short shifts are rostered in the morning, and four nurse aids are rostered in the afternoon in the hospital and rest-home. One nurse aid is rostered at night.

		The dementia unit has two nurse aids in the morning, two in the afternoon, and one at night. The RN posted in the hospital and rest-home provides assistance to the dementia unit in the morning and afternoon shifts as required. An activities person is rostered across the facility on morning shift five days a week. Activities are available 24/7 in the rest home, hospital and dementia unit. Residents and whānau reported there was a shortage of staff and that staff manage to meet the needs of the residents. The CL reported that there were adequate staff. One RN is on leave and is expected back at the end of October. At least one staff member on duty has a current first aid certificate. The CL reported that Te Whatu Ora has been informed. The GM and CL reported the provider is advertising for RNs. An afterhours on call system is in place with the CL and an RN sharing on call 24/7. Both are registered nurses with a current annual practicing certificate. The GM manager described the recruitment process includes referee checks, police vetting, and validation of qualifications and practicing certificates (APCs) where required. Meetings are held with the resident and their family/whānau to discuss and sign care plans. Resident's meetings are held quarterly to remind and inform people of changes to procedures, for example access during COVID-19 and lockdown. The CL reported it is an opportunity for people to discuss and express satisfaction with meals, maintenance and activities. Minutes for the meeting Wednesday 31st August 2022 were sighted. Continuing education is planned on an annual basis, including mandatory training requirements. Topics include dementia, IP, wound

		care, code of rights, documentation, first aid, and hand hygiene. The CL reported that three of three RNs have a current InterRAI competency. The CL reported that palliative care training was provided by an external provider. The pharmacy provided medication training and records were sighted. The CL reported undertaking training including catheter, safe feeding, aged care and aspiring manager modules. All staff participate in continuing education relevant to physical disability and young people with physical disabilities. Related competencies are assessed and support equitable service delivery. Medication competencies were sighted. Care staff have either completed, commenced or are due to commence a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. Staff reported at interview they had completed the required dementia units. The Office Administrator reported that 16 staff working in the dementia care area have either completed or are enrolled in the required education. Where health equity expertise is not available, external agencies are contacted. For example, the CL recently had training with a nurse specialist from an external provider. Staff reported feeling well supported, safe and listened to in the workplace. The CL reported supporting staff when they are unwell and providing advice to enable them to access their own medical care. The service has plans to collect and share high-quality Māori health information, training resources and competencies.
Subsection 2.4: Health care and support workers The people: People providing my support have knowledge, skills,	FA	Human resources management policies and processes are based on good employment practice and relevant legislation. A sample of seven staff records reviewed confirmed the organisation's policies are

values, and attitudes that align with my needs. A diverse mix of people in adequate numbers meet my needs. Te Tiriti: Service providers actively recruit and retain a Māori health workforce and invest in building and maintaining their capacity and capability to deliver health care that meets the needs of Māori. As service providers: We have sufficient health care and support workers who are skilled and qualified to provide clinically and culturally safe, respectful, quality care and services.		being consistently implemented. Staff performance is reviewed and discussed at regular intervals. Position descriptions are documented and were sighted in the files reviewed. The GM described the procedure to ensure professional qualifications are validated prior to employment. Current annual practising certificates were sighted for three of three registered nurses including the CL, the physiotherapist, 14 of 14 pharmacists, the dietitian, the general practitioner, podiatrist, and nurse practitioner. All were within the expiry date. Staff orientation and induction includes all necessary components relevant to the role. Topics include policies and procedures, routines, tasks, fire and emergency procedures, and IP. Staff are buddied with a colleague and complete a checklist. Evidence was sighted of completed checklists. The CL described the process including meeting with the staff person to ensure they are confident. Staff reported that the orientation process prepared them well for their role. Staff files are paper based and are held confidentially in a locked cupboard in a locked office. The GM has begun the process of collecting ethnicity data to use for recruitment purposes. Staff and the CL reported that incident reports are discussed at staff meetings. Staff have the opportunity to be involved in a debrief and discussion and receive support following incidents to ensure wellbeing.
Subsection 2.5: Information The people: Service providers manage my information sensitively	FA	Residents' files and the information associated with residents and staff are retained in electronic and hard copies. Staff have their own logins and passwords. Backup database systems are held by an external provider. All necessary demographic, personal, clinical and

and in accordance with my wishes. Te Tiriti: Service providers collect, store, and use quality ethnicity data in order to achieve Māori health equity. As service provider: We ensure the collection, storage, and use of personal and health information of people using our services is accurate, sufficient, secure, accessible, and confidential.		health information was fully completed in the residents' files sampled for review. Records are uniquely identifiable, legible, and timely including staff signatures, designation, and dates. These comply with relevant legislation, health information standards, and professional guidelines, including in terms of privacy. Resident's and staff files are held securely for the required period before being destroyed. Paper based files are archived through an external provider. Retrieving a file is managed through documentation which was sighted. No personal or private resident information was on public display during the audit. The provider is not responsible for registering residents' national health index (NHI) number. All residents have a National Health Index (NHI) number on admission.
Subsection 3.1: Entry and declining entry The people: Service providers clearly communicate access, timeframes, and costs of accessing services, so that I can choose the most appropriate service provider to meet my needs. Te Tiriti: Service providers work proactively to eliminate inequities between Māori and non-Māori by ensuring fair access to quality care. As service providers: When people enter our service, we adopt a person-centred and whānau-centred approach to their care. We focus on their needs and goals and encourage input from whānau. Where we are unable to meet these needs, adequate information about the reasons for this decision is documented and communicated to the person and whānau.	FA	The admission policy for the management of inquiries and entry to service is in place. The admission pack contains all the information about entry to the service. Assessments and entry screening processes are documented and communicated to the EPOA/whānau/family of choice, where appropriate, local communities, and referral agencies. Completed Needs Assessment and Service Coordination (NASC) service authorisation forms for residents assessed as requiring rest home, hospital, young people with disabilities (YPD) and dementia level of care were in place. Residents assessed as requiring dementia level of care were admitted with consent from EPOAs and documents sighted verified that EPOAs consented to referral and specialist services. Evidence of specialist referral to the service was sighted. Records reviewed confirmed that admission requirements are conducted within the required time frames and are signed on entry. Family/whānau were updated where there was a delay to entry to service. This was observed on the days of the audit and in inquiry records sampled. Residents and family/whānau interviewed confirmed that they were consulted and received ongoing sufficient information regarding the services provided.

		The CL reported that all potential residents who are declined entry are recorded. When an entry is declined relatives are informed of the reason for this and made aware of other options or alternative services available. The consumer/family is referred to the referral agency to ensure the person will be admitted to the appropriate service provider. There were no residents who identified as Māori at the time of the audit. The service is actively working to ensure routine analysis to show entry and decline rates including specific data for entry and decline rates for Māori is implemented. The service is actively working towards partnering with local Māori communities, health practitioners, traditional Māori healers, and organisations to support Māori individuals and whānau.
Subsection 3.2: My pathway to wellbeing The people: I work together with my service providers so they know what matters to me, and we can decide what best supports my wellbeing. Te Tiriti: Service providers work in partnership with Māori and whānau, and support their aspirations, mana motuhake, and whānau rangatiratanga. As service providers: We work in partnership with people and whānau to support wellbeing.	PA Moderate	The service uses assessment tools that included consideration of residents' lived experiences, cultural needs, values, and beliefs. Residents' care is undertaken by appropriately trained and skilled staff that include the nursing team and care staff. Cultural assessments were completed by the nursing team who have completed appropriate cultural training. Long-term care plans were also developed with detailed interventions to address identified problems. Twenty-four-hour behaviour management strategies for residents in the secure unit were completed and regularly reviewed to reflect residents' changing needs. These strategies were documented on the electronic record management system. All residents reviewed had assessments completed including behaviour, fall risk, nutritional requirements, continence, skin, cultural, and pressure injury assessments. The GP and NP visits the service once a week and is available on call when required. Medical input was sought within an appropriate timeframe, medical orders were followed, and care was person-centred. This was confirmed in the files reviewed and interview conducted with the GP. Residents' medical admission and reviews were completed. Residents' files sampled identified service integration with other members of the health team.

		Multidisciplinary team (MDT) meetings were completed annually. The CL reported that sufficient and appropriate information is shared between the staff at each handover. Interviewed staff restated that they are updated daily regarding each resident's condition. Progress notes were completed on every shift and more often if there were any changes in a resident's condition. A multidisciplinary approach is adopted to promote continuity in service delivery, and this includes the GP/NP, CL, registered nurses, care staff, physiotherapist (PT) when required, podiatrist, and other members of the allied health team, residents, and family/whanau. Short-term care plans were developed for short-term problems or in the event of any significant change with appropriate interventions to guide staff. The plans were reviewed weekly or earlier if clinically indicated by the degree of risk noted during the assessment process. These were added to the long-term care plan if the condition did not resolve in three weeks. Any change in condition is reported to the nursing team as evidenced in the records sampled. Interviews verified residents and family/whānau are included and informed of all changes. A range of equipment and resources were available, suited to the levels of care provided and the residents' needs. The family/whānau and residents interviewed confirmed their involvement in the evaluation of progress and any resulting changes. The cultural policy in place reflects the partnership and support of residents, whanau, and the extended whānau as applicable to support wellbeing. Tikanga principles are included within the cultural policy. Any barriers that prevent tangata whaikaha and whānau from independently accessing information or services are identified and strategies to manage these documented. This includes residents with a disability. The staff confirmed they understood the process to support residents and whanau. Residents who are assessed as young people with disability (YPD) had their needs identified and managed appropriately. There were 27 overdue InterRAI re-assessments with timeframes

		ranging from 8-431 days.
Subsection 3.3: Individualised activities The people: I participate in what matters to me in a way that I like. Te Tiriti: Service providers support Māori community initiatives and activities that promote whanaungatanga. As service providers: We support the people using our services to maintain and develop their interests and participate in meaningful community and social activities, planned and unplanned, which are suitable for their age and stage and are satisfying to them.	FA	Planned activities are appropriate to the residents' needs and abilities. Activities are conducted by the diversional therapist (DT). The programme runs from Monday to Friday with weekends reserved for church services, movies, EPOA/whānau/family visits and other activities are facilitated by care staff. The activities are based on assessments and reflected the residents' social, cultural, spiritual, physical, and cognitive needs/abilities, past hobbies, interests, and enjoyments. Residents' birthdays are celebrated, and resident meetings are conducted monthly. A social life history assessment detailing residents' life history is completed for each resident within two weeks of admission in consultation with the family and resident. The activity programme is formulated by the DT in consultation with the General Manager, CL, registered nurses, EPOAs, residents, and care staff. The activities are varied and appropriate for people assessed as requiring rest-home, hospital, dementia, and YPD, level of care. Residents assessed as requiring YPD care are involved in activities of their choice and reported they have access to the Wi-Fi which enables them to use their electronic gadgets. Twenty-four-hour behaviour management plans reflected residents' preferred activities of choice and are evaluated every six months or as necessary. These are documented on the resident electronic record management system. Activity progress notes and activity attendance checklists were completed daily. The residents were observed participating in a variety of activities on the audit days that were appropriate to their group settings. The planned activities and community connections were suitable for the residents. The service promotes access to EPOA/whānau/family and friends. Outings are conducted as required in the company of EPOA/whānau/family and friends except under COVID-19 national restrictions. There were no residents who identified as Māori. The DT reported that opportunities for Māori and whānau to participate in te ao Māori is facilitated through community engagements with community traditional leaders, and by celebrating religious, and cultural festivals

		and Te Wiki o Te Māori. EPOA/whānau/family and residents reported overall satisfaction with the level and variety of activities provided.
Subsection 3.4: My medication The people: I receive my medication and blood products in a safe and timely manner. Te Tiriti: Service providers shall support and advocate for Māori to access appropriate medication and blood products. As service providers: We ensure people receive their medication and blood products in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	The medication management policy was current and in line with the Medicines Care Guide for Residential Aged Care. There is a medication management policy in place. A safe system for medicine management (an electronic system) is in use. This is used for medication prescribing, dispensing, administration, review, and reconciliation. Administration records are maintained. Medications are supplied to the facility from a contracted pharmacy. The GP/NP completes three monthly medication reviews. Indications for use are noted for pro re nata (PRN) medications, including, over the counter medications and supplements. Allergies are indicated, and all photos uploaded on the electronic medication management system were current. Eye drops were dated on opening. Medication reconciliation is conducted by the nursing team when a resident is transferred back to the service from the hospital or any external appointments. The nursing team checked medicines against the prescription, and these were updated in the electronic medication management system. Medication competencies were current, and these were completed in the last 12 months for all staff administering medicines. Medication incidents were completed in the event of a drug error and corrective actions were acted upon. A sample of these was reviewed during the audit. There were no expired or unwanted medicines. Expired medicines are returned to the pharmacy promptly. Weekly and six-monthly stocktakes were completed as required. Monitoring of medicine fridge and medication room temperatures is conducted regularly and deviations from normal were reported and attended to promptly. Records were sighted. The RN was observed administering medications safely and correctly

		in the hospital and rest home wing respectively. Medications were stored safely and securely in the trolley, locked treatment room, and cupboards. There were no residents self-administering medicines. There is a self-medication policy in place, and this was sighted. There were no standing orders in use. The medication policy clearly outlines that residents, including Māori residents and their whānau, are supported to understand their medications.
Subsection 3.5: Nutrition to support wellbeing The people: Service providers meet my nutritional needs and consider my food preferences. Te Tiriti: Menu development respects and supports cultural beliefs, values, and protocols around food and access to traditional foods. As service providers: We ensure people's nutrition and hydration needs are met to promote and maintain their health and wellbeing.	FA	The kitchen service complies with current food safety legislation and guidelines. All food and baking is prepared and cooked on site by a contracted service. There was an approved food control plan which expires on 7 April 2023. The menu was reviewed by a registered dietitian on 27 June 2022. Kitchen staff have current food handling certificates. Diets are modified as required and the kitchen staff confirmed awareness of the dietary needs of the residents. Residents have a nutrition profile developed on admission which identifies dietary requirements, likes, and dislikes. All alternatives are catered for as required. The residents' weights are monitored regularly, and supplements are provided to residents with identified weight loss issues. Snacks and drinks are available for residents throughout the day and night when required. The kitchen and pantry were observed to be clean, tidy, and stocked. Regular cleaning is undertaken, and all services comply with current legislation and guidelines. Labels and dates were on all containers. Thermometer calibrations were completed every three months. Records of temperature monitoring of food, fridges, and freezers are maintained, and these are recorded on the electronic management system. EPOA/whānau/family and residents interviewed indicated satisfaction with the food service. All decanted food had records of use by dates

		recorded on the containers and no expired items were sighted. The kitchen staff reported that the service prepares food that is culturally specific to different cultures. This includes menu options which are culturally specific to te ao Māori.
Subsection 3.6: Transition, transfer, and discharge The people: I work together with my service provider so they know what matters to me, and we can decide what best supports my wellbeing when I leave the service. Te Tiriti: Service providers advocate for Māori to ensure they and whānau receive the necessary support during their transition, transfer, and discharge. As service providers: We ensure the people using our service experience consistency and continuity when leaving our services. We work alongside each person and whānau to provide and coordinate a supported transition of care or support.	FA	There is a documented process in the management of the early discharge/unexpected exit plan and transfer from services. The CL reported that discharges are normally into other similar facilities. Discharges are overseen by the clinical team who manage the process until exit. All this is conducted in consultation with the resident, family/whānau, and other external agencies. Risks are identified and managed as required. A discharge or transition plan will be developed in conjunction with the residents and family/whānau (where appropriate) and documented on the residents' file. Referrals to other allied health providers were completed with the safety of the resident identified. Upon discharge, current and old notes are collated and scanned onto the resident's electronic management system. If a resident's information is required by a subsequent GP/NP, a written request is required for the file to be transferred. Evidence of residents who had been referred to other specialist services, such as podiatrists, gerontology nurse specialists, and physiotherapists, were sighted in the files reviewed. Residents and EPOA/family/whānau are involved in all exits or discharges to and from the service and there was sufficient evidence in the residents' records to confirm this.
Subsection 4.1: The facility The people: I feel the environment is designed in a way that is safe and is sensitive to my needs. I am able to enter, exit, and move around the environment freely and safely. Te Tiriti: The environment and setting are designed to be Māori-	FA	A current building warrant of fitness is publicly displayed. It expires on 30 September 2023. Appropriate systems are in place to ensure the residents' physical environment and facilities internal and external are fit for their purpose, well maintained and that they meet legislative requirements. Tagging and testing is current as confirmed in records, interviews with

centred and culturally safe for Māori and whānau. As service providers: Our physical environment is safe, well maintained, tidy, and comfortable and accessible, and the people we deliver services to can move independently and freely throughout. The physical environment optimises people's sense of belonging, independence, interaction, and function.		the GM and maintenance personnel, and observation. The maintenance personnel is contracted and has been in the role for 18 months. The GM described the maintenance schedule which was sighted. Residents confirmed they know the processes they should follow if any repairs or maintenance is required, any requests are appropriately actioned and that they are happy with the environment. The environment is comfortable and accessible, promoting independence and safe mobility. Personalised equipment was available for residents with disabilities to meet their needs. Spaces were culturally inclusive and suited the needs of the resident groups. Communal areas are available for residents to engage in activities. The facility is accessible to meet the mobility and equipment needs of people receiving services. Three dining and four lounge areas are spacious and enable easy access for residents and staff. An area is set aside for visitors with screening to provide privacy. Furniture is appropriate to the setting and residents' needs. There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. Two resident's rooms share a bathroom. All other rooms have an ensuite. The number of toilet and bathroom facilities for visitors and staff are adequate. Appropriately secured and approved handrails are provided in the bathroom areas, and other equipment are available to promote resident's independence. Adequate personal space is provided to allow residents and staff to move around within the bedrooms safely. Six bedrooms provide shared accommodation but are used as single rooms. Rooms are personalised with furnishings, photos and other personal items displayed.

		There is room to store mobility aids, and wheelchairs. Staff, residents and family/whānau reported the adequacy of bedrooms. Residents and whānau were happy with the environment, including heating and ventilation, privacy and maintenance. The GM reported that the organisation will seek involvement from residents, whānau and liaise with Māori within the community in the design of any new buildings.
Subsection 4.2: Security of people and workforce The people: I trust that if there is an emergency, my service provider will ensure I am safe. Te Tiriti: Service providers provide quality information on emergency and security arrangements to Māori and whānau. As service providers: We deliver care and support in a planned and safe way, including during an emergency or unexpected event.	FA	Disaster and civil defence plans and policies direct the facility in their preparation for disasters and described the procedures to be followed. Emergency evacuation plans are displayed and known to staff. The current fire evacuation plan was approved by the New Zealand Fire Service on 16 April 1999. A record of the last trial evacuation held on 9 June 2022 was sighted. The services emergency plan considers the special needs of young people with disabilities in an emergency. The orientation programme includes fire and security training. Staff files evidenced staff are trained in emergency procedures. Staff confirmed their awareness of the emergency procedures and attend regular fire drills. Manual call boxes, floor plans, hose reels, sprinklers alarms, and fire action notices were sighted. The GM and CL reported that all staff have a current first aid certificate. Call bells alert staff to residents requiring assistance. Residents and whānau reported staff respond promptly to call bells. Appropriate security arrangements are in place. Windows have security stays. Doors are kept secure 24/7. Staff are provided with an access card. A call bell procedure is in place for visitors to enter the facility. Adequate supplies for use in the event of a civil defence emergency, including food, personal protective equipment (PPE), and medical supplies meet the requirements for the residents. Stored water meets the National Emergency Management Agency recommendations for

		the region. Backup power is provided through batteries. Emergency lighting is regularly tested. Residents and family/whānau are informed of the emergency and security arrangements at entry. They reported being familiar with the arrangements.
Subsection 5.1: Governance The people: I trust the service provider shows competent leadership to manage my risk of infection and use antimicrobials appropriately. Te Tiriti: Monitoring of equity for Māori is an important component of IP and AMS programme governance. As service providers: Our governance is accountable for ensuring the IP and AMS needs of our service are being met, and we participate in national and regional IP and AMS programmes and respond to relevant issues of national and regional concern.	FA	The infection prevention (IP) and antimicrobial stewardship (AMS) programmes are appropriate to the size and complexity of the service, have been approved by the governing body, link to the quality improvement system and are reviewed and reported on yearly. The CL reported that expertise and advice are sought from for example Te Whatu Ora, GP, nurse practitioner and the laboratory. A documented pathway supports reporting of progress, issues and significant events to the governing body. Reports to the board include infections. Board meeting minutes confirmed this. A pandemic response plan is documented and has been regularly tested. The plan was sighted.
Subsection 5.2: The infection prevention programme and implementation The people: I trust my provider is committed to implementing policies, systems, and processes to manage my risk of infection. Te Tiriti: The infection prevention programme is culturally safe. Communication about the programme is easy to access and navigate and messages are clear and relevant. As service providers: We develop and implement an infection prevention programme that is appropriate to the needs, size, and scope of our services.	FA	The service has a documented infection prevention and control programme that is reviewed annually. Review of the programme is completed by the CL who is appointed as the infection prevention and control coordinator (IPCC). A position description for the IPCC was in place. The service has guidelines to manage and prevent exposure to infections. Infection prevention and control training is provided to staff, residents, and visitors. There were adequate supplies of personal protective equipment (PPE) and hand sanitisers in stock. Hand washing and other infection control audits were not being completed (refer to 2.2.2). Staff are advised not to attend work if they are unwell or self-isolate and get tested if they have been in contact with a person who has tested positive for COVID-19. Most residents and all

		staff were vaccinated for COVID-19 and influenza. Completed records were sighted in all files sampled. There was a pandemic outbreak plan in place. Information and resources to support staff in managing COVID-19 were regularly updated. Visitor screening and residents' temperature monitoring records, depending on alert levels by Te Whatu Ora, were documented. COVID-19 rapid antigen tests (RATs) are being conducted for staff and visitors when indicated before coming on-site. There were two exposure events due to Covid-19 in February to April 2022, and July to August 2022, and total of 10 residents were affected, both events were managed according to policy. The facility was closed to the public, with GP/NP, EPOA/whānau /family, residents, and relevant authorities notified promptly. Documented evidence of meetings with DHB, staff, and EPOA/whānau/family notifications was sighted. There are documented policies and procedures for managing both manual and automated decontamination of reusable medical devices. Internal audits are completed, and all corrective actions are documented, as verified. The service has documented policies and procedures in place that reflected current best practices. Policies and procedures are accessible and available for staff through the electronic record management system. Care delivery, cleaning, laundry, and kitchen staff were observed following organisational policies, such as appropriate use of hand sanitizers, good hand washing technique, and use of disposable aprons and gloves. Staff demonstrated knowledge of the requirements of standard precautions and were able to locate policies and procedures. Staff training on infection prevention and control is routinely provided during orientation and annual in-service education. In-service education is conducted by either the CL or other external facilitators. The infection training includes handwashing procedures, donning and doffing protective equipment, and regular COVID-19 updates. Records of staff education were maintained. The CL completed

		various infection prevention and control training online, such as hand hygiene, pandemic planning, outbreak training, RAT testing, donning and doffing PPE. The service is actively working towards including infection prevention information in te reo Māori. They are also working towards ensuring that the infection prevention personnel and committee work in partnership with Māori for the protection of culturally safe practices in infection prevention and acknowledging the spirit of Te Tiriti.
Subsection 5.3: Antimicrobial stewardship (AMS) programme and implementation The people: I trust that my service provider is committed to responsible antimicrobial use. Te Tiriti: The antimicrobial stewardship programme is culturally safe and easy to access, and messages are clear and relevant. As service providers: We promote responsible antimicrobials prescribing and implement an AMS programme that is appropriate to the needs, size, and scope of our services.	FA	The service is committed to responsible use of antimicrobials. The effectiveness of the AMS programme is evaluated by monitoring antimicrobial use and identifying areas for improvement. The CL is responsible for implementing the infection control programme and indicated there are adequate people, physical, and information resources to implement the programme. Infection control reports are completed monthly, and these are discussed at management and staff meetings. Staff confirmed that infection rates information is shared in a timely manner. The IPC has access to all relevant residents' data to undertake surveillance, internal audits, and investigations, respectively. Specialist support can be accessed through the district health board, the medical laboratory, and the attending GP/NP.
Subsection 5.4: Surveillance of health care-associated infection (HAI) The people: My health and progress are monitored as part of the surveillance programme. Te Tiriti: Surveillance is culturally safe and monitored by ethnicity. As service providers: We carry out surveillance of HAIs and multi-drug-resistant organisms in accordance with national and regional surveillance programmes, agreed objectives, priorities, and methods specified in the infection prevention programme, and with an equity focus.	FA	Surveillance of health care-associated infections (HAIs) is appropriate to that recommended for long term care facilities and is in line with priorities defined in the infection control programme. The data is collated and analysed monthly to identify any significant trends or common possible causative factors. Results of the surveillance data are shared with staff during shift handovers, at monthly staff meetings, and health and safety quality/meetings. Infection data is compiled, documented, and reported to the general manager and the board. All monthly infection control reports, infection control surveillance, and yearly infection control report were sighted. Infection control audits were completed, and corrective actions implemented. Staff interviewed confirmed that they are informed of infection rates as they occur. The GP/NP was informed on time when a resident has an

		infection and appropriate antibiotics were prescribed for all diagnosed infections. The service is actively working towards ensuring surveillance of healthcare-associated infections includes ethnicity data.
Subsection 5.5: Environment The people: I trust health care and support workers to maintain a hygienic environment. My feedback is sought on cleanliness within the environment. Te Tiriti: Māori are assured that culturally safe and appropriate decisions are made in relation to infection prevention and environment. Communication about the environment is culturally safe and easily accessible. As service providers: We deliver services in a clean, hygienic environment that facilitates the prevention of infection and transmission of antimicrobial resistant organisms.	FA	The policy describes safe and appropriate storage and disposal of waste, and infectious or hazardous substances, including storage and use of chemicals. Material safety data sheets were available where chemicals are stored, and staff interviewed knew what to do should any chemical spill/event occur. No hazardous substances were detected on site. All staff interviewed demonstrated awareness of safe and appropriate disposal of waste. Used continence and sanitary products are disposed of appropriately in disposal containers stored in a safe place outside. There were sharps boxes in the medication room. Personal protective equipment (PPE) including gloves, aprons, and goggles are available for staff throughout the facility. Staff was observed to be using personal protective equipment, including changing gloves after every procedure. Laundry such as personal clothes and blankets are washed on-site, or by family members if requested, in the well-equipped laundry which has a clear separation of clean and dirty areas. Towels, sheets and pillowcases are washed offsite by a contracted company. The resident and family/ whānau interviewed expressed satisfaction with the laundry management and reported that the clothes are returned promptly. Cleaning is outsourced as well and staff received appropriate annual training in chemical safety and infection control, including COVID-19. Chemicals were decanted into appropriately labelled containers. Chemicals are stored in labelled containers in the locked storeroom. There are cleaning rooms where all cleaning trollies are kept locked. Safety data sheets were available in the laundry, kitchen, sluice rooms, and chemical storage areas.

		The effectiveness of cleaning and laundry processes was not being monitored through the internal audit programme (refer to 2.2.2). Cleaning of frequently touched areas and accessed areas was increased due to COVID-19. The residents and family members interviewed reported that the environment was clean. The care staff demonstrated a sound knowledge of the laundry processes.
Subsection 6.1: A process of restraint The people: I trust the service provider is committed to improving policies, systems, and processes to ensure I am free from restrictions. Te Tiriti: Service providers work in partnership with Māori to ensure services are mana enhancing and use least restrictive practices. As service providers: We demonstrate the rationale for the use of restraint in the context of aiming for elimination.	FA	Maintaining a restraint free environment is the aim of the service. The chairperson, GM and CL reported a commitment to this. At the time of audit one resident was using a restraint in the form of a lap belt when the resident is in an armchair. The consent form was sighted. The GM and CL reported that when restraint is used, this is as a last resort when all alternatives have been explored. The CL is the restraint coordinator providing support and oversight for any restraint management. Staff have been trained in the least restrictive practice, safe restraint practice, alternative interventions, and de-escalation techniques. The use of restraint used is reported to the GM through the quality and risk management meetings. Policies and procedures meet the requirements of the standard.
Subsection 6.2: Safe restraint The people: I have options that enable my freedom and ensure my care and support adapts when my needs change, and I trust that the least restrictive options are used first. Te Tiriti: Service providers work in partnership with Māori to ensure that any form of restraint is always the last resort. As service providers: We consider least restrictive practices, implement de-escalation techniques and alternative interventions, and only use approved restraint as the last resort.	FA	Assessments for the use of restraint, monitoring and evaluation was documented and included all requirements of the Standard. The family/whānau, GM and enduring power of attorney (EPOA) had signed the consent form which was sighted. The care plan was sighted. The CL reported that the use of the lap belt was used as a last resort to prevent the resident falling. A restraint register is maintained and reviewed at handover. The register contained enough information to provide an auditable record. Staff record when the lap belt is applied and when it is removed. Staff record the effectiveness of the lap belt. Records were sighted.

		The restraint approval group are responsible for the approval of the use of restraints and the restraint processes. The CL reported that no injuries have occurred through the use of the lap belt. The CL reported and staff confirmed that they understand the reasons for the use of the restraint. Should a debrief be needed, the CL reported they would provide the support to the staff. The CL reported that the use of the lap belt varies each day. Records evidenced a variation of the amount of time and the number of days the restraint was used. Records evidenced it was used for one hour during a 24-hour period.
Subsection 6.3: Quality review of restraint The people: I feel safe to share my experiences of restraint so I can influence least restrictive practice. Te Tiriti: Monitoring and quality review focus on a commitment to reducing inequities in the rate of restrictive practices experienced by Māori and implementing solutions. As service providers: We maintain or are working towards a restraint-free environment by collecting, monitoring, and reviewing data and implementing improvement activities.	FA	The CL reported that the restraint committee, including the family/ whānau and EPOA undertakes a six-monthly review of the restraint use which includes all the requirements of the Standard. The outcome of the review is reported to the GM. The GM confirmed this. The use of restraint is intermittent depending on the person's wellbeing.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.7.7 My advance directives (written or oral) shall be followed wherever possible.	PA Low	The GP/NP makes a clinically based decision on resuscitation authorisation in consultation with residents and family/whanau and review them annually. However, five (5) of six (6) resuscitation authorisation forms in the files sampled were not reviewed annually as per policy requirements. The CL reported that advance directives are explained and encouraged. All residents admitted to the dementia unit had activated EPOAs in place.	Five of six resuscitation authorisation forms sampled were not reviewed annually as per policy requirements.	Ensure resuscitation authorisation forms are reviewed annually as per policy requirements. 180 days
Criterion 2.2.2 Service providers shall develop and implement a quality management framework using a risk-based approach to improve service	PA Low	Internal audits were sighted for year 2019. They were not sighted for the period 2019 until September 2022. There was no current internal audit schedule in line with the requirement of the organisation's quality policy. The client files audit showed	There was no current internal audit schedule in line with the requirement of the organisation's quality policy. There was no documented audit of	Develop and provide evidence of the annual internal audit schedule. Ensure internal audits are completed and documented in line with

delivery and care.		InterRAI assessments had not been completed (refer 3.2.2). The GM reported the level of cleaning and that the laundry tasks had been completed were visual checks. There were no documented records for these two areas. There was no audit of infection control practice. Resident meeting minutes evidenced a level of satisfaction through feedback in the areas of menu options, quality of the food, level of care received from staff, quality of accommodation, and the number and type of activities.	cleaning, laundry, or infection control practice.	the schedule. 90 days
Criterion 2.3.1 Service providers shall ensure there are sufficient health care and support workers on duty at all times to provide culturally and clinically safe services.	PA Moderate	Five days a week, there is at least one RN in the hospital and rest-home on the morning and afternoon shifts between 8am and 11pm weekdays. There is no RN on site at night. Three TLs have been appointed to mitigate the absence of an RN. Two TLs are nurses who are registered in their country of origin, but the registration is not recognized in New Zealand. Qualifications were sighted. One TL is a senior nurse aid with 30+ years' experience. A training package was developed for the TLs by the nurse educator who is an RN with a current practicing certificate. The RN has worked alongside the TLs for 18 months. The provider has not sought an exemption from Te Whatu Ora Te Toka Tumai Auckland. At the time this audit was undertaken, there was a significant national health workforce shortage. Findings in this audit relating to staff shortages should be read in the context of this national issue.	There is no RN on site at night. An exemption has not been sought.	Provide evidence that a registered nurse is rostered night shift seven days per week. 90 days

Criterion 3.2.5 Planned review of a person's care or support plan shall: (a) Be undertaken at defined intervals in collaboration with the person and whānau, together with wider service providers; (b) Include the use of a range of outcome measurements; (c) Record the degree of achievement against the person's agreed goals and aspiration as well as whānau goals and aspirations; (d) Identify changes to the person's care or support plan, which are agreed collaboratively through the ongoing re-assessment and review process, and ensure changes are implemented; (e) Ensure that, where 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.	PA Moderate	All six (6) residents' files sampled identified that initial assessments and initial care plans were resident centred, and these were completed on admission. Where progress was different from expected, the service, in collaboration with the resident or family/whānau, responded by initiating changes to the care plan. The long-term care plans sampled reflected identified residents' strengths, goals, and aspirations aligned with their values and beliefs documented. Evaluations included the residents' degree of progress towards their agreed goals and aspirations as well as whānau goals and aspirations. Documented detailed strategies to maintain and promote the residents' independent well-being were sighted. There were 27 overdue InterRAI re-assessments ranging from 8 to 431 days. The CL reported that this was due to shortage of InterRAI trained registered nurses at the service and only three RNs were InterRAI trained. Recruitment of more registered nurses was underway. The General Manager and CL reported that the service was actively working towards completing all overdue InterRAI assessments. Resident, family/whānau/EPOA, and GP/NP involvement is encouraged. Not completing all required assessments, had a potential of not managing residents' identified needs as required. In all the care plans reviewed care needs were being identified and managed appropriately.	Twenty-Seven InterRAI assessments were overdue for review ranging from 8 to 431 days.	Ensure all InterRAI assessments are completed as per policy and Te Whatu Ora Te Toka Tumai Auckland contractual requirements. 90 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.