

# Experion Care NZ Limited - Wensley House

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## Introduction

This report records the results of a Surveillance Audit of a provider of aged residential care services against the Ngā paerewa Health and disability services standard (NZS8134:2021).

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

The abbreviations used in this report are the same as those specified in section 0.4 of the Ngā paerewa Health and disability services standard (NZS8134:2021).

You can view a full copy of the standard on the Manatū Hauora website by clicking [here](#).

The specifics of this audit included:

<b>Legal entity:</b>	Experion Care NZ Limited
<b>Premises audited:</b>	Wensley House
<b>Services audited:</b>	Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 26 September 2023    End date: 27 September 2023
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	24

# Executive summary of the audit

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## Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six sections contained within the Ngā paerewa Health and disability services standard:

- ō tātou motika | our rights
- hunga mahi me te hanganga | workforce and structure
- ngā huarahi ki te oranga | pathways to wellbeing
- te aro ki te tangata me te taiao haumarū | 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 are fully attained with some subsections exceeded
	No short falls	Subsections applicable to this service are 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 are 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 are 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 are 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 24 residents on the day of audit.

This unannounced surveillance audit was conducted against a subset of the Ngā Paerewa Health and Disability Standard 2021 and contracts with Te Whatu Ora Health New Zealand – Nelson Marlborough. The audit process included the review of policies and procedures, the review of resident and staff files, observations, interviews with residents, family/whānau, management, staff, and a general practitioner.

There has been a change of management since the previous audit. The service has installed a new electronic resident management system, and a new call bell system.

The service has addressed four of the previous 13 shortfalls around communication; the complaint process; pandemic planning; and cleanliness. There are ongoing improvements required around review of business goals; aspects of the quality system; education; care planning timeframes; care planning interventions; medication management; emergency management checks; aspects of food services; and outbreak management.

This surveillance audit identified further shortfalls around admission agreements; staffing; staff first aid certificates; staff files; aspects of management; aspects of maintenance; fire drills; infection control policies; and training around restraint.

## Ō tātou 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 are partially attained and of low risk.
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There is a Māori and Pacific health plan documented for the service. Staff interviewed were knowledgeable around cultural safety. The Code of Residents Rights is displayed in English and te reo Māori. Complaint forms are accessible, and the complaint process aligns with Health and Disability requirements.

## Hunga mahi me te hanganga | Workforce and structure

Includes five subsections that support an outcome where people receive quality services through effective governance and a supported workforce.		Some subsections applicable to this service are partially attained and of medium or high risk and/or unattained and of low risk.
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There is an organisational business plan documented which includes site specific goals. Staff meetings are held regularly. Staff were knowledgeable around hazard management.

## Ngā huarahi ki te oranga | Pathways to wellbeing

<p>Includes eight 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.</p>		<p>Some subsections applicable to this service are partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The registered nurses assess, plan and review residents' needs, outcomes, and goals, but with no evidence of resident and/or family/whānau input. Care plans do not always demonstrate service integration. Resident files included medical notes by the contracted general practitioners and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. The electronic medicine charts reviewed met prescribing requirements and were reviewed at least three-monthly by the general practitioner.

The kitchen staff cater to individual cultural and dietary requirements. The service has a current food control plan.

All residents' transfers and referrals are coordinated with residents and families/whānau.

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

Includes two 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 are partially attained and of medium or high risk and/or unattained and of low risk.

The building holds a current building warrant of fitness. Electrical equipment has not been tested and tagged. All medical equipment has been serviced and calibrated.

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

Includes five 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 are partially attained and of medium or high risk and/or unattained and of low risk.

There is work to be done around the implementation of the infection control programme.

## Here taratahi | Restraint and seclusion

Includes four subsections that support outcomes where Services shall aim for a restraint and seclusion free environment, in which people’s dignity and mana are maintained.		Some subsections applicable to this service are partially attained and of low risk.
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The facility was restraint free. There is a current restraint policy in place.

## 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	9	0	2	11	0	0
Criteria	0	37	0	6	17	0	0

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

# Attainment against the Ngā paerewa Health and disability services standard

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

For more information on the standard, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Subsection with desired outcome	Attainment Rating	Audit Evidence
<p>Subsection 1.1: Pae ora healthy futures</p> <p>Te Tiriti: Māori flourish and thrive in an environment that enables good health and wellbeing.</p> <p>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.</p>	FA	<p>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.</p> <p>The policy recognises the importance of the partnership with tāngata whenua under the Treaty of Waitangi. The policy includes a cultural assessment and Māori care plan that includes the four elements of Te Whare Tapa Whā: 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 has no residents or staff who identify as Māori. Staff interviewed (one registered nurse [RN], four caregivers, one cook, and one maintenance) were knowledgeable in accepted cultural practices in relation to their roles. Care staff described getting to know each resident's preferences in relation to Te Tiriti.</p>
<p>Subsection 1.2: Ola manuia of Pacific peoples in Aotearoa</p> <p>The people: Pacific peoples in Aotearoa are entitled to live and enjoy good health and wellbeing.</p>	FA	<p>The Pacific health plan has been developed by an external contractor in partnership with a Pacific organisation. There are cultural policies documented to guide staff around caring for residents from Pacific</p>

<p>Te Tiriti: Pacific peoples acknowledge the mana whenua of Aotearoa as tuakana and commit to supporting them to achieve tino rangatiratanga.</p> <p>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.</p>		<p>nations. Caregivers interviewed described getting to know resident's individual preferences.</p>
<p>Subsection 1.3: My rights during service delivery</p> <p>The People: My rights have meaningful effect through the actions and behaviours of others.</p> <p>Te Tiriti: Service providers recognise Māori mana motuhake (self-determination).</p> <p>As service providers: We provide services and support to people in a way that upholds their rights and complies with legal requirements.</p>	<p>FA</p>	<p>The Code of Health and Disability Services Consumers' Rights (the Code) is displayed in English and te reo Māori. The facility manager (interviewed) described how it is provided with admission information and can be available in a range of languages as required. Staff are trained around the Code of Rights at orientation and as part of the training programme.</p>
<p>Subsection 1.5: I am protected from abuse</p> <p>The People: I feel safe and protected from abuse.</p> <p>Te Tiriti: Service providers provide culturally and clinically safe services for Māori, so they feel safe and are protected from abuse.</p> <p>As service providers: We ensure the people using our services are safe and protected from abuse.</p>	<p>FA</p>	<p>Wensley House policies prevent any form of institutional racism, discrimination, coercion, harassment, or any other exploitation. There are policies, and protocols to respect resident's property, including an established process to manage and protect resident finances.</p> <p>The staff interviewed demonstrated an understanding of professional boundaries; however, training has not been held (link 2.3.4).</p>
<p>Subsection 1.6: Effective communication occurs</p> <p>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.</p> <p>Te Tiriti: Services are easy to access and navigate and give clear and relevant health messages to Māori.</p> <p>As service providers: We listen and respect the voices of the</p>	<p>FA</p>	<p>Incident reports and resident files reviewed evidenced open communication with family/whānau where there had been an adverse event or changes in resident condition. The relative interviewed stated there had been a marked improvement since the employment of the current RN and manager. The relative felt they were informed promptly when their family member had a fall, GP appointment, and was informed of any changes. The previous shortfall has been addressed.</p>

<p>people who use our services and effectively communicate with them about their choices.</p>		
<p>Subsection 1.7: I am informed and able to make choices</p> <p>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.</p> <p>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.</p> <p>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.</p>	<p>PA Low</p>	<p>There are policies around informed consent. The service follows relevant best practice tikanga guidelines. The registered nurses have a good understanding of the organisational process to ensure informed consent for Māori residents involved the family for collective decision making. Interviews with the relative and five residents confirmed their choices regarding decisions and their wellbeing is respected.</p> <p>The admission agreement is discussed with the residents and family/whānau on or before admission and appropriately signed by the resident or the enduring power of attorney (EPOA); however, not all resident records had signed admission agreements in place.</p>
<p>Subsection 1.8: I have the right to complain</p> <p>The people: I feel it is easy to make a complaint. When I complain I am taken seriously and receive a timely response.</p> <p>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.</p> <p>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.</p>	<p>FA</p>	<p>The complaints procedure is provided to residents and families/whānau during the resident's entry to the service. Access to complaint forms is located at the entrance to the facility or on request from staff. Complaints can be handed to the manager who is based at reception. Residents or relatives making a complaint can involve an independent support person in the process if they choose. The complaints process is linked to advocacy services. The Code of Health and Disability Services Consumers' Rights and complaints process is visible, and available in te reo Māori, and English. All information around complaints can be made available in a range of languages as required.</p> <p>There were two previous folders with complaints, which have not been maintained. The current manager has set up a new complaint file which evidenced two internal complaints made by residents around food services. The complaints were acknowledged, investigated and letters of the outcomes were sent to the complainants. The complainants both signed the resolution part of the letter to confirm they were happy with the</p>

		<p>outcome, and meals had improved. One of these residents were interviewed and felt the complaint had been dealt with appropriately and was resolved to their satisfaction. The previous shortfall has been addressed.</p>
<p><b>Subsection 2.1: Governance</b></p> <p>The people: I trust the people governing the service to have the knowledge, integrity, and ability to empower the communities they serve.</p> <p>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.</p> <p>As service providers: Our governance body is accountable for delivering a highquality service that is responsive, inclusive, and sensitive to the cultural diversity of communities we serve.</p>	<p>PA Moderate</p>	<p>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).</p> <p>Wensley House is located in Richmond, Nelson and 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 21 residents in the care facility and three in the serviced apartments. All residents except two were on the age-related residential care agreement (ARRC). Two residents were under 65; one resident was under a mental health contract; and one resident was funded by ACC.</p> <p>The 2022-2025 business plan outlines the business initiatives for 2023, vision, mission and values and provides an overview of the current governance structure. The business plan (signed as approved by the director in September 2023) includes site specific goals for Wensley House which includes an organisational chart for the facility. Key objectives include (but not limited to) implementation of an electronic management system, installation of a resident call bell system, and completion of previous audit shortfalls. The director, clinical governance lead and manager interviewed report they have been monitoring progress of achieving goals; however, minutes of these meetings and reviews were not available on site. The previous shortfall remains an area for improvement.</p> <p>Currently there is no Board of Directors; however, during discussion with the director and the clinical governance lead (RN), they are in the process of adding two other Board members who are New Zealand based and are experienced in governance roles in relation to age care; one of whom is the cultural advisor. The director and clinical governance lead are working on documenting terms of reference; orientation of the new Board members will include visits to all of the facilities.</p> <p>Currently the director (sole owner) is supported by an accounts/business</p>

	<p>manager, human resources consultant and legal support. The director interviewed has been based in India and visits New Zealand regularly.</p> <p>The manager completes weekly reports to the clinical governance lead who provides clinical governance across the organisation. The report template (sighted) provides an overview of clinical and operational aspects of the facility. During discussion with the clinical governance lead, they reported they are collating the information. During the audit, the organisation was in the process of installing an electronic resident management system across all sites. Wensley House had this installed two weeks prior to the audit. The clinical governance lead described how the implementation of this system will assist them with the collation of data for benchmarking, which is planned to go live from 1 January 2024.</p> <p>There has been an issue-based audit held in May 2023, the management were working through corrective actions identified at that report. Progress was sited.</p> <p>The director and clinical governance lead described identifying services and resources as well as supporting residents and family/whānau to access these as required in each of the regions, to minimise barriers to care for residents. Transport is provided for appointments. The cultural advisor is available to provide support for residents and Māori residents are encouraged and supported to maintain their personal linkages in the community to improve outcomes. The cultural safety policy states Experion “acknowledge the Indigenous rights of Māori within New Zealand and supports the principles of the Treaty of Waitangi. Although health is only one contributing factor to equity, Experion have a leadership role in helping clients achieve cultural safety in health care and are committed to best practice in order to achieve health equity for Māori.</p> <p>The clinical governance lead and the director have completed training around embedding the principles of Te Tiriti o Waitangi.</p> <p>The manager has been in the role since June 2023 and has experience in management in aged care settings throughout New Zealand. The manager is a registered nurse with a current practicing certificate. The manager is supported by an experienced registered nurse who has been in the role since May 2023, an administrator, and a team of experienced staff.</p>
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<p>Subsection 2.2: Quality and risk</p> <p>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.</p> <p>Te Tiriti: Service providers allocate appropriate resources to specifically address continuous quality improvement with a focus on achieving Māori health equity.</p> <p>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.</p>	<p>PA Moderate</p>	<p>Wensley House has a quality and risk management programme documented by an external consultant; however, this has not yet been implemented at Wensley House. 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 2022; however, the business plan now includes site specific objectives. This part of the previous shortfall has been addressed.</p> <p>There was evidence (online) of updated policies which were accessible to the manager; however, the policies in hardcopy available to staff were not current. This is an ongoing shortfall. The clinical governance lead reported the updated policies are planned to be uploaded to the recently installed electronic resident management system and will be accessible for all staff. This portion of the previous shortfall remains ongoing.</p> <p>There is an internal audit schedule documented; however, internal audits have not been completed according to the schedule, with no evidence of internal audits being completed since March 2023. Where audits have been completed, there was evidence of corrective actions being identified; however, these have not been followed up or signed off as completed. The previous shortfall remains ongoing.</p> <p>Quality data was being collated, including infections and adverse events; however, there was no documented evidence of analysis of the collated data. The clinical governance lead described how the resident management system will enable them to export data to form reports with the view to benchmarking internally across the organisation. This is planned to 'go live' from January 2024.</p> <p>Satisfaction surveys were held March 2022; however, there was no documented evidence of analysis of the results to include high and low areas of satisfaction across the service. There has not been a satisfaction survey held in 2023.</p> <p>The clinical governance lead had identified the implementation of the quality and risk programme as an issue. The clinical governance lead provided evidence of the progression towards streamlining all of the</p>

		<p>quality and risk programme across all of the sites, including meetings and internal audit schedules, satisfaction surveys, templates for reporting, agendas, and meeting minute templates etc.</p> <p>A schedule for facility meetings was not located. Of the meeting minutes sighted, combined quality and staff meetings were held regularly and evidence discussion of quality data and include a debrief meeting following a Covid-19 outbreak. Meeting minutes in the first half of 2023 appear sporadic, with none held until July and August of 2023. Since the employment of the current manager, these have been held monthly; however, meeting minutes did not reflect discussion around analysis of quality data as described during interviews with staff.</p> <p>Health and safety is discussed in the combined quality/staff meeting. The staff interviewed were knowledgeable and could describe hazard reporting and minimisation. Incident/accidents are recorded in hard copy. Ten accident/incident forms reviewed indicated that the forms completed in full. Incident and accident data does not appear to be formally collated monthly, and there was no evidence of analysis. Numbers and types of incidents are discussed in the combined quality and staff meetings.</p> <p>Discussions with the manager and clinical governance lead evidenced their awareness of their requirement to notify relevant authorities in relation to essential notifications. The notification of the change of management was not on sight; the clinical lead reported this had been completed.</p>
<p>Subsection 2.3: Service management</p> <p>The people: Skilled, caring health care and support workers listen to me, provide personalised care, and treat me as a whole person.</p> <p>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.</p> <p>As service providers: We ensure our day-to-day operation is managed to deliver effective person-centred and whānau-</p>	<p>PA Moderate</p>	<p>There is a staffing policy documented that describes rostering. A sample of rosters were reviewed for the months of August and September 2023, which evidenced gaps in the roster where staff have been off sick or unable to be employed into the role.</p> <p>The manager and staff reported moderate levels of staff turnover. The manager has recently signed up with an agency to provide caregiver shifts till the roles have been filled.</p> <p>The 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,</p>

<p>centred services.</p>		<p>including oversight of the key components of the quality and risk management system. A full-time RN was employed in May 2023 and has recently resigned from the position. The clinical governance lead and the manager reported there is an RN from a sister facility who will cover the RN role until the vacancy has been filled. Residents and family members interviewed reported the manager to be available and responsive to their needs.</p> <p>The rosters and training records evidenced that there was not always a staff member on duty with a current first aid certificate, when the RN was not on site (link 4.2.4).</p> <p>Staff interviewed confirmed they are supported to complete New Zealand Qualification Authority (NZQA) qualifications through Careerforce. There were four caregivers who have achieved a level 4 qualification in Health and Wellbeing. There are a number of staff who have signed up to the training.</p> <p>The education planners for 2022 and 2023 were reviewed. Not all compulsory education sessions or competencies were covered as scheduled in 2022 and this has not been implemented in 2023. Training records evidenced the number of staff who attended the training sessions provided in 2022; however, there was no record of training held in 2023. Content of training sessions was evident for the training sessions held. The clinical governance lead and the manager report they had identified this issue and are setting up login details for an online training platform. The previous shortfall (# 2.3.4) remains ongoing. Training records evidenced not all staff who administer medications on night shifts have current medication competencies (link # 3.4.3). The RN and the manager are interRAI trained.</p>
<p>Subsection 2.4: Health care and support workers</p> <p>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.</p> <p>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</p>	<p>PA Moderate</p>	<p>There are human resources policies in place, including recruitment, selection, orientation, and staff training and development. Staff files are held in the general manager's office in a locked filing cabinet. Six staff files reviewed (three caregivers, one RN, one recently employed kitchenhand, and one recently employed cleaner) evidenced implementation of the recruitment process, employment contracts, police checking and reference checks; however, not all staff files evidenced a</p>

<p>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.</p>		<p>completed role specific orientation. There was no evidence of orientation for the manager or registered nurse, and there was no evidence of staff appraisals being completed since 2019.</p> <p>There are job descriptions in place for caregiver, RN and non-clinical staff positions that include outcomes, accountability, responsibilities, authority, and functions to be achieved in each position. However, there were no job descriptions included in staff files for extra profiles, including the restraint coordinator, infection control coordinator and health and safety representative.</p> <p>A register of practising certificates is maintained. The clinical governance lead is available to provide peer support if required.</p>
<p>Subsection 3.2: My pathway to wellbeing</p> <p>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.</p> <p>Te Tiriti: Service providers work in partnership with Māori and whānau, and support their aspirations, mana motuhake, and whānau rangatiratanga.</p> <p>As service providers: We work in partnership with people and whānau to support wellbeing.</p>	<p>PA Moderate</p>	<p>Five electronic and paper-based rest home resident files were reviewed, including one under mental health contract residing in the serviced apartments. All other residents were under the age-related residential care (ARRC) agreement. The service has in the last month moved to an electronic resident management system with all records now kept and updated electronically.</p> <p>The full-time registered nurse (RN) is responsible for conducting all residents' assessments, care planning and evaluation of care. The manager (RN) has oversight of all admissions and resident transfers. At the time of audit, the facility was not admitting any residents. As per policy, all residents have admission assessment information collected and an initial care plan developed within 24 hours; however, there were no admission assessments and initial care plans sighted in some of the records reviewed. The previous audit shortfall (#3.2.1) remains ongoing. The registered nurse and manager advised that there have been significant staffing challenges over the last 12 months, which have affected their ability to keep on top of expected documentation requirements.</p> <p>The long-term care plan includes sections on mobility; culture; continence; care and hygiene; nutrition; pain management; sleep; communication; medication; skin care; cognitive function; and behaviours. Risk assessments related to the care plan sections are completed by the registered nurse, with appropriate interventions developed; however, the</p>

	<p>long-term care plans reviewed (electronic and paper) do not provide detailed interventions for identified risks to provide guidance for caregivers in care delivery. The previous audit shortfall (#3.2.3) remains ongoing. There is no evidence of involvement of residents and family/whānau in assessment and care planning processes. Not all long-term care plans have been updated with identified changes in care needs, and not all interRAI assessments have been completed within the required timeframes.</p> <p>Evaluations are scheduled to be completed six-monthly and not all were up to date. Care evaluations have not occurred as required for four of the five resident files reviewed (one had recently had a review completed and as such, documentation met required standards). Written evaluations for the recently reviewed resident record identified if the resident goals had been met or unmet. Short-term care plans (STCPs) have been utilised for issues such as infections; however, not all identified acute needs had a short-term care plan commenced or the long-term care plan updated. Of the short-term care plans reviewed, these had been reviewed and closed off in a timely manner. This part of the previous audit shortfall # 3.2.5 has been met.</p> <p>All resident records reviewed 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 and for the records reviewed this has occurred as scheduled. There is evidence the GP reviews residents earlier if required. There are two main medical practices contracted to provide medical oversight. They visit the facility as needed and in some instances families and staff can take the resident to the practice for review. There is a three-monthly schedule developed by the registered nurse which is shared with the general practitioners for proactive planning of visits (sighted on the day of audit). On call is provided by a local after-hours clinic or the emergency department. The general practitioner (interviewed) was complimentary on the service being provided by the team. The GP confirmed that systems and processes had significantly improved since the current registered nurse started in May 2023. They confirmed the service has good working relationships with specialists, including mental health services at Te Whatu Ora Health New Zealand - Nelson Marlborough. There is access to a continence specialist as required. A podiatrist visits regularly and a dietitian, speech language therapist, hospice, wound care nurse specialist and medical specialists</p>
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	<p>are available as required through the local Te Whatu Ora Health New Zealand- Nelson Marlborough. However, allied health and general practitioner input and instructions were not always documented as interventions in the long-term care plan, or a short-term care plan commenced as indicated.</p> <p>Caregivers 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. The clinical progress notes (including daily forms) are recorded and maintained on the electronic resident management system. This is an improvement since the previous audit.</p> <p>Residents interviewed reported their needs and expectations were being met. When a resident's condition alters, the registered nurse initiates a review with a general practitioner. The incident forms provided evidence of registered nurse follow up and whānau notifications. Progress notes reviewed provide evidence that whānau have been notified of changes to health, including infections, GP visits, medication changes and any changes to health status. This was confirmed with family/whānau interviewed on the day of the audit.</p> <p>An adequate supply of wound care products were available at the facility. A review of the wound care plans evidenced wounds were assessed in a timely manner and reviewed at appropriate intervals. Photos were taken where this was required. Where wounds required additional specialist input, this was initiated, and a wound nurse specialist was consulted. At the time of the audit, there were two active wounds from one resident (skin tear and leg ulcer), with the leg ulcer receiving input from the wound nurse specialist. Assessments and plans were completed as scheduled. Both wounds were reviewed and showed evidence of healing, with the skin tear signed off as healed on the dressing change form completed on the day of the audit.</p> <p>Caregivers complete monitoring charts including bowel chart, blood pressure and blood sugar levels and these have been completed as scheduled. Neurological observations have been completed for unwitnessed falls. This is an improvement on the previous audit.</p>
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<p>Subsection 3.4: My medication</p> <p>The people: I receive my medication and blood products in a safe and timely manner.</p> <p>Te Tiriti: Service providers shall support and advocate for Māori to access appropriate medication and blood products.</p> <p>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.</p>	<p>PA Moderate</p>	<p>There are policies available for safe medicine management that meet legislative requirements. The service has been working on completion of medication competencies for staff who administer medications. To date, eight staff have completed the medication competency; however, there are staff who may need to administer medication during the night without medication competencies. The registered nurse has completed syringe driver training.</p> <p>Staff were observed to be safely administering medications. The registered nurse and medication caregivers interviewed could describe their role regarding medication administration. The service currently uses blister packs for regular, short course and 'as required' medications. All medications are checked on delivery against the medication chart and any discrepancies are fed back to the supplying pharmacy.</p> <p>Medications were appropriately stored in the facility medication room. The medication fridge and medication room temperatures are monitored daily; however, these were not recorded consistently and there were no records sighted or available prior to July 2023 for the fridge and prior to June 2023 for the room temperature monitoring. This is an ongoing shortfall. All stored medications are checked monthly. Eyedrops have been dated on opening. Weekly checks of controlled drugs have been recorded as occurring and medication trollies were clean. These parts of the previous shortfall # 3.4.1 have been met. The Non-Prescription, Complementary and Alternative Remedies/ Medicines/ Treatment policy is documented and guides staff around management of over-the-counter medications. The previous recommendation (# 3.4.8) has been addressed.</p> <p>Ten electronic medication charts were reviewed. The medication charts reviewed identified that the GP had reviewed all resident medication charts three-monthly. The previous shortfall (# 3.4.2) has been addressed. Each drug chart has photo identification and allergy status identified. The previous shortfall (# 3.4.4) has been addressed. Effectiveness of pro re nata (PRN) medication are recorded in the progress notes and electronic medication chart; however, not all charts and records reviewed demonstrated documentation on the effectiveness of PRN medications given to residents. There were two residents self-administering medications; however, one resident did not have a self-administration assessment completed; this is an ongoing shortfall. No</p>
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		<p>vaccines are kept on site and no standing orders are used.</p> <p>There was documented evidence in the clinical files that residents and relatives are updated around medication changes, including the reason for changing medications and side effects. When medication related incidents occurred, these were investigated and followed up on.</p>
<p>Subsection 3.5: Nutrition to support wellbeing</p> <p>The people: Service providers meet my nutritional needs and consider my food preferences.</p> <p>Te Tiriti: Menu development respects and supports cultural beliefs, values, and protocols around food and access to traditional foods.</p> <p>As service providers: We ensure people's nutrition and hydration needs are met to promote and maintain their health and wellbeing.</p>	<p>PA Moderate</p>	<p>The food service is overseen by a qualified chef who works full time four days a week. The chef is supported by another chef who works the other three days. All meals and baking are prepared and cooked on site. The four-week seasonal menu is reviewed by a registered dietitian. Food preferences and cultural preferences are encompassed into the menu. The kitchen receives resident dietary forms and is notified of any dietary changes for residents. All dietary forms reviewed were current and reflective of resident's needs; this part of the previous shortfall (# 3.5.3) has been addressed. Dislikes and special dietary requirements are accommodated, including food allergies. The cook interviewed reported they accommodate residents' requests.</p> <p>Observation of the meal service confirmed that meals delivered to the rooms were covered. The previous shortfall has been addressed.</p> <p>There is a verified food control plan expiring 19 October 2024. Food serving temperature checks have not been recorded since previous audit; this is an ongoing shortfall. The only records sighted were from June 2023. Fridge and freezer temperatures were recorded; however, frequencies are inconsistent; this is an ongoing shortfall. There is partial decanting of dry goods. Decanted foods in the pantry were dated. This part of the previous shortfall (#3.5.3) has been addressed. Observation and interview with the chef confirmed that eggs were constantly moved between fridge and pantry based on storage space. The previous shortfall remains ongoing.</p> <p>The residents and family/whānau interviewed were complimentary regarding the standard of food provided.</p>
<p>Subsection 3.6: Transition, transfer, and discharge</p>	<p>FA</p>	<p>There were documented policies and procedures to ensure exiting,</p>

<p>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.</p> <p>Te Tiriti: Service providers advocate for Māori to ensure they and whānau receive the necessary support during their transition, transfer, and discharge.</p> <p>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.</p>		<p>discharging or transferring residents have a documented transition, transfer, or discharge plan, which includes current needs and risk mitigation. Planned exits, discharges or transfers were coordinated in collaboration with the resident (where appropriate), family/whānau and other service providers to ensure continuity of care.</p>
<p>Subsection 4.1: The facility</p> <p>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.</p> <p>Te Tiriti: The environment and setting are designed to be Māori-centred and culturally safe for Māori and whānau.</p> <p>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.</p>	<p>PA Moderate</p>	<p>The buildings, plant, and equipment are fit for purpose. The current building warrant of fitness expires 17 May 2024. There is a maintenance request book for repair and maintenance requests located in the nurse's station. Equipment failure or issues are also recorded in the maintenance book. This is checked daily and signed off when repairs have been completed. There is no evidence of an annual maintenance plan being in place and completed to include electrical testing and tagging, equipment checks, call bell checks, calibration of medical equipment and monthly testing of hot water temperatures. Essential contractors/tradespeople are available 24 hours a day as required. Hot water temperature recording reviewed evidence that checks have been completed and recorded monthly; however, there were no corrective actions undertaken when temperature reading was outside of expected ranges.</p>
<p>Subsection 4.2: Security of people and workforce</p> <p>The people: I trust that if there is an emergency, my service provider will ensure I am safe.</p> <p>Te Tiriti: Service providers provide quality information on emergency and security arrangements to Māori and whānau.</p> <p>As service providers: We deliver care and support in a planned and safe way, including during an emergency or unexpected event.</p>	<p>PA Moderate</p>	<p>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.</p> <p>There is no current fire evacuation plan approved by the New Zealand Fire Service that could be sighted on the day of the audit. Fire evacuation drills have not been completed every six months. There are emergency management plans in place to ensure health, civil defence and other</p>

		<p>emergencies are included. Civil defence supplies are stored centrally. There continues to be expired stock in the emergency cupboard and the emergency cupboard contents checklist has not been implemented; this is an ongoing shortfall.</p> <p>Emergency management is included in the staff orientation and training plan; however, with the exception of the registered nurse, there is no other staff member who has completed first aid training available on duty and for resident van outings.</p>
<p>Subsection 5.1: Governance</p> <p>The people: I trust the service provider shows competent leadership to manage my risk of infection and use antimicrobials appropriately.</p> <p>Te Tiriti: Monitoring of equity for Māori is an important component of IP and AMS programme governance.</p> <p>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.</p>	FA	<p>All visitors are required to sign in at reception. Signage was displayed advising visitors not to visit if feeling unwell. Hand sanitiser is placed throughout the facility for staff, residents, and visitors to use. There was evidence of a debrief meeting held post Covid-19 break in 2022. The previous shortfall # 5.1.4 has been addressed.</p>
<p>Subsection 5.2: The infection prevention programme and implementation</p> <p>The people: I trust my provider is committed to implementing policies, systems, and processes to manage my risk of infection.</p> <p>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.</p> <p>As service providers: We develop and implement an infection prevention programme that is appropriate to the needs, size, and scope of our services.</p>	PA Moderate	<p>There was no documented infection control programme available on the day of the audit, and a review of the 2022 programme could not be located. The education plan has not been implemented, therefore, staff have not completed infection control training.</p>

<p>Subsection 5.4: Surveillance of health care-associated infection (HAI)</p> <p>The people: My health and progress are monitored as part of the surveillance programme.</p> <p>Te Tiriti: Surveillance is culturally safe and monitored by ethnicity.</p> <p>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.</p>	<p>PA Moderate</p>	<p>There is no defined infection control coordinator role (link 2.4.2). The registered nurse identifies when a resident has an infection and alerts the GP, documents progress notes, and implements a short-term care plan. The RN and manager report a very low incidence of infections. The RN reports any infections to the manager who includes this data in the weekly reports to the clinical governance lead. Benchmarking has not yet commenced, and there was no evidence of collation of ethnicity data with infection control data.</p> <p>A record of infections is maintained; however, results are not collated and analysed. Infection data is discussed at the combined quality and staff meetings; however, there is no evidence of analysis and corrective actions identified.</p> <p>There have been no outbreaks since the current manger has been employed. Meeting minutes were documented following an outbreak of Covid-19 in June 2022; however, no documentation around the outbreak could be located.</p>
<p>Subsection 5.5: Environment</p> <p>The people: I trust health care and support workers to maintain a hygienic environment. My feedback is sought on cleanliness within the environment.</p> <p>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.</p> <p>As service providers: We deliver services in a clean, hygienic environment that facilitates the prevention of infection and transmission of antimicrobialresistant organisms.</p>	<p>FA</p>	<p>There are policies around waste management (link #2.2.3). Material safety datasheets are available in the two laundries and in cleaners' cupboard. Personal protective equipment including gloves, aprons and eyewear are available for staff throughout the 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. The kitchen was observed to be clean and cleaning schedules were maintained. There is an external company who maintains pest control. The previous shortfall (#5.5.3) has been addressed.</p>
<p>Subsection 6.1: A process of restraint</p> <p>The people: I trust the service provider is committed to improving policies, systems, and processes to ensure I am free from restrictions.</p>	<p>PA Low</p>	<p>There is a restraint policy in place which was current. The policy states the service is committed to promoting a restraint-free environment and to provide the staff with good guidelines to enable them to prevent the need for restraint.</p>

<p>Te Tiriti: Service providers work in partnership with Māori to ensure services are mana enhancing and use least restrictive practices.</p> <p>As service providers: We demonstrate the rationale for the use of restraint in the context of aiming for elimination.</p>		<p>There is no defined role for the restraint coordinator (link 2.4.2); however, the manager assumes the role. There were no residents using restraints on the days of the audit.</p> <p>The manager reported if the need for restraint should occur, data would be collated and discussed at the meetings and reported to the governance lead who would alert the director. There has been no education provided in the last two years around challenging behaviour or restraint minimisation. The staff interviewed could describe what a restraint is, monitoring and documentation processes, The RN and manager described the approval process, gaining consent and working alongside the resident and the family/whānau if restraint was required.</p>
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## 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)
<p>Criterion 1.7.1</p> <p>I shall have the right to make an informed choice and give informed consent.</p>	PA Low	There are policies in place around informed consent. The manager is responsible for discussing the admission agreement with residents and EPOA on or before admission, and to ensure the agreement is appropriately signed and saved within the resident’s records. At the time of the audit, there were two of five resident records that did not have signed resident admission agreements completed.	Two of five files reviewed did not have a copy of signed admission agreements completed.	<p>Ensure there are resident admission agreements appropriately signed and on file for all residents.</p> <p>90 days</p>
<p>Criterion 2.1.2</p> <p>Governance bodies shall ensure service providers’ structure, purpose, values, scope, direction, performance, and goals are</p>	PA Moderate	There is an organisational business plan documented 2022- 2025, which includes vision, mission, and values. The business plan includes organisational and site specific; however, while the facility has achieved most of the goals set for 2023,	There is no documented evidence of meetings held to review organisational and facility goals.	Ensure all discussions of organisational and site-specific goals are documented.

clearly identified, monitored, reviewed, and evaluated at defined intervals.		there was no documented evidence on site of review meetings and progression towards meeting goals. This is an ongoing shortfall.		60 days
<p>Criterion 2.2.3</p> <p>Service providers shall evaluate progress against quality outcomes.</p>	<p>PA</p> <p>Moderate</p>	<p>The quality and risk programme along with policies and procedures has been purchased from an aged care provider; however, this has not always been fully implemented. Policies and procedures are up to date and available online to the manager; however, hard copy policies available to staff are outdated. A selection of internal audits were completed in 2022; however, not all of the audits were held according to schedule and internal audits have not been completed since March 2023. The internal audits that have been completed identify corrective actions; however, there was no evidence of follow up or sign off once these were addressed. Meeting minutes are available and have been held regularly since the employment of the current manager; however, meeting minutes do not evidence discussion around analysis of data.</p>	<p>i). The quality and risk management programme has not been fully implemented.</p> <p>ii). Up to date policies and procedures are only accessible to the manager.</p> <p>iii). Internal audits have not been held according to schedule.</p> <p>iv). Corrective actions identified were not evidenced as being followed up or signed off when completed.</p> <p>v). Satisfaction survey results were not evidenced as being analysed for 2022, and there has been no survey held in 2023.</p> <p>vi). Meeting minutes reviewed do not identify discussion around the analysis of quality data or satisfaction survey results as described during staff interviews.</p> <p>vii). There was no evidence of analysis of any quality data.</p>	<p>i). Ensure the quality and risk programme is fully implemented.</p> <p>ii). Ensure current policies and procedures are available to all staff.</p> <p>iii). Ensure internal audits are held according to schedule.</p> <p>iv). Ensure all corrective actions identified are evidenced as being followed up and signed off when completed.</p> <p>v). Ensure satisfaction surveys are held at least annually, and results are analysed.</p> <p>vi). Ensure meeting minutes reflect discussions around the analysis of quality data and satisfaction results held.</p> <p>vii). Ensure quality data collated through incident and infection reports are analysed.</p>

				60 days
<p>Criterion 2.3.1</p> <p>Service providers shall ensure there are sufficient health care and support workers on duty at all times to provide culturally and clinically safe services.</p>	PA Low	<p>At the time of the audit, the service was meeting contractual requirements around RN staffing; however, in the last two months rosters reviewed there were shifts where the roster had not been able to be filled as a result of staff sickness and two caregiver vacancies. The manager reported they are advertising for staff currently. The manager has recently signed up with an agency to relieve the staffing pressures; however, there are occasions where the agency has been unable to provide cover. Staff report the RN is very helpful and assists them where possible; however, staff felt stretched particularly on the afternoon shifts.</p> <p>The roster provides four caregivers from 7am to 3.30pm. The afternoon shift has two caregivers rostered from 3pm to 11.30 pm, and one short shift from 4pm to 10pm. The nightshift has two caregivers rostered from 11pm to 7.30pm. Due to the decreased numbers of residents, there were days where four caregivers were rostered on morning shift (due to individualised contract requirements), and others where there were two caregivers rostered for a morning shift. On afternoon shifts there were days where two caregivers were rostered (full shifts), and others where the short shift was able to be covered. The rosters reviewed evidenced up to three shifts (across morning and afternoon shifts) per day not covered. Nightshifts were consistently covered.</p>	<p>There were gaps in the rosters for up to three caregivers short per day across the morning and afternoon shifts.</p>	<p>Ensure there is adequate staff rostered on duty to meet the needs of the residents.</p> <p>90 days</p>

<p>Criterion 2.3.4</p> <p>Service providers shall ensure there is a system to identify, plan, facilitate, and record ongoing learning and development for health care and support workers so that they can provide high-quality safe services.</p>	<p>PA Moderate</p>	<p>There is an education plan documented for 2023; however, this has not been fully implemented, and is not evidenced as being fully implemented in 2022. Education records available on the day of the audit evidenced not all compulsory training sessions or competencies have been held within the last two years; this is identified as an ongoing shortfall. This has been identified by the manager as a gap also and the service is in the process of setting up login details for staff to access online training. The manager reports they have booked training with the Advocacy service to complete a session around resident Code of Rights, advocacy, and informed consent in early December. Training in 2022 included a cultural competency, falls prevention, medication management, continence management and confidentiality.</p>	<p>There was no evidence of staff completing training around the ageing process; skin integrity; wound management; pressure injury management; health and safety; informed consent; advocacy; code of conduct; and residents Code of Rights in the last two years.</p>	<p>Ensure all compulsory training sessions and staff competencies are held according to schedule.</p> <p>90 days</p>
<p>Criterion 2.4.2</p> <p>Service providers shall ensure the skills and knowledge required of each position are identified and the outcomes, accountability, responsibilities, authority, and functions to be achieved in each position are documented.</p>	<p>PA Low</p>	<p>There are job descriptions in place for caregivers, manager, non-clinical staff, and the RN; however, there were no job descriptions in place outlining roles and responsibilities for extra roles, including the infection control coordinator, health and safety representative and restraint coordinator.</p>	<p>There were no job descriptions in place for positions including the infection control coordinator, health and safety representative and restraint coordinator.</p>	<p>Ensure extra roles are defined in job descriptions, including the infection control coordinator, health and safety representative, and restraint coordinator.</p> <p>90 days</p>
<p>Criterion 2.4.4</p> <p>Health care and support</p>	<p>PA Moderate</p>	<p>There are policies documented to guide the manager around recruitment processes. The staff files reviewed all had signed</p>	<p>i). There was no evidence of completed orientations for five of the six staff files reviewed, including</p>	<p>Ensure all staff complete a role specific orientation and a signed</p>

workers shall receive an orientation and induction programme that covers the essential components of the service provided.		contracts, reference checks, police vetting checks, and a signed job description on file. Ethnicity is documented in staff files; however, the staff files reviewed did not always have the completed orientation documentation on file.	two staff who were employed in mid-2023.  ii). There was no evidence of orientation for the manager or registered nurse.	copy is retained on staff files.  90 days
Criterion 2.4.5 Health care and support workers shall have the opportunity to discuss and review performance at defined intervals.	PA Low	Of the staff files reviewed for staff who had been employed for more than a year, there was no evidence of completed appraisals since 2019.	There was no evidence of appraisals being completed for staff who have been employed for more than a year.	Ensure all staff have an annual appraisal as per policy.  90 days
Criterion 3.2.1 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 involved when the person receiving services requests this.	PA Moderate	The assessment and support planning policy provides guidance on all assessments being completed by an RN in partnership with residents and family/whānau. An initial care plan is developed within 24 hours of admission to provide guidance for healthcare assistants on care delivery for the residents. However, most of the files reviewed did not have an initial assessment and care plan, current interRAI assessments, and current / reviewed long-term care plans. There was no documented evidence of resident and/or family/whānau input into assessments and care planning.	i). Four out of five interRAI assessments are not current. ii). Four out of five residents did not have initial assessments and an initial care plan on file. iii). There was no documented evidence of resident or family/whānau input into assessments and care planning.	i). -iii). Ensure assessments and care plans are completed in line with timeframes. iv). Ensure family input into assessments and care planning is documented.  60 days
Criterion 3.2.3 Fundamental to the development of a care or support plan shall be that:	PA Moderate	The registered nurse is responsible for the development of the support plan. Assessment tools including (but not limited to) cultural, falls risk, nutritional, skin, behaviour and interRAI assessments are	There were no detailed interventions in the long-term care plans of four of five residents to support care delivery related to: a). Pressure injury prevention and	Ensure long-term care plans are current with detailed interventions to manage and guide the

<p>(a) Informed choice is an underpinning principle;</p> <p>(b) A suitably qualified, skilled, and experienced health care or support worker undertakes the development of the care or support plan;</p> <p>(c) Comprehensive assessment includes consideration of people's lived experience;</p> <p>(d) Cultural needs, values, and beliefs are considered;</p> <p>(e) Cultural assessments are completed by culturally competent workers and are accessible in all settings and circumstances. This includes traditional healing practitioners as well as rākau rongoā, mirimiri, and karakia;</p> <p>(f) Strengths, goals, and aspirations are described and align with people's values and beliefs. The support required to achieve these is clearly documented and communicated;</p> <p>(g) Early warning signs and risks that may adversely affect a person's wellbeing are recorded, with a focus on prevention or escalation for appropriate intervention;</p> <p>(h) People's care or support plan identifies wider service</p>		<p>completed to identify key risk areas. Alerts are indicated on the resident care plan and include (but not limited to) high falls risk, weight loss, wandering and pressure injury risks. The registered nurse interviewed described their responsibility in relation to care planning. However, the care plans reviewed did not have detailed interventions to provide guidance to caregivers in relation to care delivery for the residents. This was especially evident for residents with pressure injury risk who did not have interventions related to pressure injury prevention, as well as pain management. Other residents where interventions were not detailed or documented include those with challenging behaviour, falls risk (and having had fall incidents recorded), hyperglycaemic signs and symptoms, and management thereof and recurring skin infections.</p> <p>Where the residents have been reviewed and assessed by the general practitioner and allied health with long term management plans, these have not always been added to the long-term care plan. There are comprehensive policies in place related to assessment and support planning; however, not all resident care plans reviewed provided sufficient information related to assessed risks, interventions, and care planning to demonstrate compliance.</p> <p>Caregivers interviewed were knowledgeable about the care needs of the residents and the families/whānau interviewed were complimentary of the care provided.</p>	<p>management; b). Pain management; c) Triggers and behaviour management; d). Signs and symptoms and management of hyperglycaemia for an insulin dependent diabetic resident; e) Falls management for a resident with frequent falls; and f). Management of recurring skin infections.</p>	<p>care of the residents.</p> <p>60 days</p>
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integration as required.				
<p>Criterion 3.2.5</p> <p>Planned review of a person's care or support plan shall:</p> <p>(a) Be undertaken at defined intervals in collaboration with the person and whānau, together with wider service providers;</p> <p>(b) Include the use of a range of outcome measurements;</p> <p>(c) Record the degree of achievement against the person's agreed goals and aspiration as well as whānau goals and aspirations;</p> <p>(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;</p> <p>(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</p>	<p>PA Moderate</p>	<p>There are policies in place which include care plan evaluations; however, not all care plans have been updated when there have been changes in resident condition or routinely at least six monthly.</p>	<p>(i). Where the residents had been seen by GP or allied health their long-term care plan was not updated or short-term care plan commenced for two residents in relation to use of a foot brace, long-term indigestion concerns and management of compression stockings. (ii). Four out of five long-term care plans were last reviewed or updated more than six months ago.</p>	<p>(i). Ensure interventions are documented in a care plan for acute issues as guided by the policy. (ii). Ensure long-term care plans are reviewed and updated at least six-monthly.</p> <p>60 days</p>

support plan.				
<p>Criterion 3.4.1</p> <p>A medication management system shall be implemented appropriate to the scope of the service.</p>	<p>PA</p> <p>Moderate</p>	<p>There is a policy and process on safe medicine management, including reconciliation, storage, and documentation requirements. However, medication room and fridge temperature monitoring and documentation were not consistently demonstrating compliance with policy, standards, and legislative requirements. Staff were not always documenting the outcome or effectiveness of pro re nata (PRN) medications when they were administered.</p>	<p>i). Medication room and fridge temperatures are not monitored and recorded consistently as per policy.</p> <p>ii). Four of ten charts did not demonstrate documentation on the effectiveness of PRN medication administered to residents.</p>	<p>i). Ensure that medication room temperature monitoring is completed.</p> <p>ii). Ensure effectiveness of PRN medication is consistently documented.</p> <p>60 days</p>
<p>Criterion 3.4.3</p> <p>Service providers ensure competent health care and support workers manage medication including: receiving, storage, administration, monitoring, safe disposal, or returning to pharmacy.</p>	<p>PA</p> <p>Moderate</p>	<p>Education has been provided in 2022 around medication management. The facility has been working on ensuring all staff who administer medications have current medication competencies in place. To date, there are eight staff who administer medications through the morning and afternoon shifts who have recently completed medication competencies. However, there are two staff working on night shifts who do not yet have a medication competency in place. The manager reports there are no residents who require medications after 11pm, and if there is a need to administer PRN medications, the staff on duty would contact the on-call RN or a medication competent member of staff to administer the medication.</p>	<p>Two staff on night shift have not completed a medication competency.</p>	<p>Ensure all staff who administer or may need to administer medications, has a current competency in place.</p> <p>60 days</p>

<p>Criterion 3.4.6</p> <p>Service providers shall facilitate safe self-administration of medication where appropriate.</p>	<p>PA Moderate</p>	<p>Medication management policies includes a resident self-medication policy and self-administration competency, which states the resident will be assessed three-monthly by the GP. On the day of the audit, there was one of two residents self-administering medications without evidence of an assessment being completed.</p>	<p>One of two residents who self-administer medications did not have a self-administration assessment completed.</p>	<p>Ensure self-administration competency is completed.</p> <p>60 days</p>
<p>Criterion 3.5.3</p> <p>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.</p>	<p>PA Moderate</p>	<p>There are polices in place to guide the nutritional wellbeing of residents. There is a qualified chef who has been working at the service since March 2022. The food control plan documented verification to 19 October 2024. Safe storage and monitoring systems have not demonstrated compliance with expected standards. This includes serving food, fridge and freezer temperature monitoring not being recorded consistently. Storage of eggs continues to demonstrate non-compliance with interview with the chef confirming that the same set of eggs can be regularly moved between fridge and pantry. On the day of the audit, they were stored in the pantry.</p>	<p>i). There is no documented evidence of fridge and freezer temperature monitoring being completed consistently each day.</p> <p>ii). Eggs are routinely stored in the pantry and moved around between fridge and pantry on occasions.</p>	<p>i)- ii). Ensure the food control plan is implemented to include relevant temperature checks and safe food storage.</p> <p>60 days</p>
<p>Criterion 4.1.1</p> <p>Buildings, plant, and equipment shall be fit for purpose, and comply with legislation relevant to the health and disability service being provided. The environment is inclusive of</p>	<p>PA Moderate</p>	<p>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. The reactive maintenance requests are classified according to risk. There is no evidence of an annual preventative maintenance plan initiated and implemented for the service. This was</p>	<p>i). Test and tag of all electrical equipment sighted has not been completed. Most equipment certificates expired March 2023.</p> <p>ii). There is no planned maintenance schedule in place.</p> <p>iii). There is no evidence of corrective actions being completed</p>	<p>i). Ensure test and tag of all electrical equipment is completed.</p> <p>ii). Ensure there is a planned maintenance schedule in place.</p> <p>iii). Ensure corrective actions are put in place</p>

peoples' cultures and supports cultural practices.		further confirmed by interview with the maintenance person and facility manager. Hot water temperatures are checked by the maintenance person and recorded in the maintenance folder monthly. However, where the temperature recordings were out of expected range, there is no evidence of corrective action being put in place. Essential contractors/tradespeople are available 24 hours as required. Review of electrical equipment in the facility demonstrated that test and tag of equipment was due in March 2023 and to date has not been completed. Medical equipment calibration was completed with the next one due July 2024.	for hot water temperature monitoring results that are out of range of the acceptable limits.	for hot water temperatures out of expected range.  60 days
Criterion 4.2.1 Where required by legislation, there shall be a Fire and Emergency New Zealand- approved evacuation plan.	PA Moderate	Emergency management procedures guide staff to complete a safe and timely evacuation of the facility in the case of an emergency; however, there was no approved fire evacuation plan from Fire and Emergency New Zealand that could be sighted on the day of the audit. It is evident that the service has completed a successful fire evacuation on 30 August 2023, with a documented plan for six-monthly fire drills going forward. However, there is no evidence of fire drills having been completed six-monthly prior to August 2023. Records indicate a fire drill having been completed March 2022 and no other drills since then.	i). Since the last audit, there is no evidence of fire drills having been completed six-monthly. The last fire drill was completed 30 August 2023 and prior to that, there was one completed March 2022.  ii). There is no copy of the New Zealand Fire Service's approval of an evacuation scheme.	i). Ensure fire drills are completed six-monthly.  ii). Ensure that there is an approved evacuation scheme.  90 days
Criterion 4.2.2	PA	There are emergency flip charts throughout	i). The emergency cupboard	i). Ensure monthly

<p>Service providers shall ensure there are implemented fire safety and emergency management policies and procedures identifying and minimising related risk.</p>	<p>Moderate</p>	<p>the facility and at the nurse's station. An up-to-date evacuation resident list is readily available at the location of the flipcharts.</p> <p>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. However, there are expired stock in the cupboards and the contents checklist has not been implemented.</p>	<p>contents checklist has not been implemented.</p> <p>ii). There continues to be expired stock in the emergency cupboard.</p>	<p>emergency cupboard checks are implemented as per policy.</p> <p>ii). Ensure emergency cupboard contents are removed and replaced when damaged or expired.</p> <p>60 days</p>
<p>Criterion 4.2.4</p> <p>Service providers shall ensure health care and support workers are able to provide a level of first aid and emergency treatment appropriate for the degree of risk associated with the provision of the service.</p>	<p>PA Moderate</p>	<p>Emergency management policies outline specific emergency responses as well as the duties and responsibilities of staff in the event of an emergency. However, review of the records indicate that the registered nurse is the only staff with current first aid training. When the registered nurse is not on duty, the service does not have a first aid trained staff member, therefore, unable to respond appropriately to emergencies.</p>	<p>There is no first aid trained staff on duty 24/7 when the registered nurse is not rostered on. The registered nurse is the only staff with current first aid training.</p>	<p>Ensure that there is a first aid trained staff member on duty 24/7.</p> <p>90 days</p>
<p>Criterion 5.2.2</p> <p>Service providers shall have a clearly defined and documented IP programme that shall be:</p> <p>(a) Developed by those with IP expertise;</p> <p>(b) Approved by the governance body;</p> <p>(c) Linked to the quality improvement programme;</p>	<p>PA Low</p>	<p>The infection control programme or plan could not be located on the day of the audit. There are documented policies and procedures developed by an external consultant. There is no documented evidence that an annual review of the IC programme has been completed.</p>	<p>i). The infection control plan could not be located on the day of the audit.</p> <p>ii). The review of the 2022 infection control plan could not be located.</p>	<p>i). Ensure the infection control programme is readily available and implemented.</p> <p>ii). Ensure the infection control programme is reviewed annually.</p> <p>90 days</p>

and (d) Reviewed and reported on annually.				
<p>Criterion 5.2.6</p> <p>Infection prevention education shall be provided to health care and support workers and people receiving services by a person with expertise in IP. The education shall be:</p> <p>(a) Included in health care and support worker orientation, with updates at defined intervals;</p> <p>(b) Relevant to the service being provided.</p>	<p>PA Moderate</p>	<p>The education plans have not been fully implemented in 2022 and 2023. There was no evidence of staff completing infection control training and handwashing competencies.</p>	<p>There was no evidence of infection control training or hand washing competencies being completed in the last two years.</p>	<p>Ensure all staff completed infection control training and handwashing competencies at least annually.</p> <p>60 days</p>
<p>Criterion 5.4.3</p> <p>Surveillance methods, tools, documentation, analysis, and assignment of responsibilities shall be described and documented using standardised surveillance definitions. Surveillance includes ethnicity data.</p>	<p>PA Moderate</p>	<p>There was no evidence of formal collation or analysis of infection control data. Infection control data does not include ethnicity. The RN reports all infections to the manager who discusses the infection type and numbers of infections in the combined staff and quality meetings, as evidenced in staff interviews and meeting minutes. There was evidence of two outbreaks in June and December 2022; however, documentation and notifications around this could not be located. Meeting minutes reviewed evidenced a debrief meeting following the June 2022 outbreak.</p>	<p>i). There is no evidence of formal collation and analysis of infection control data.</p> <p>ii). Infection control stats do not include ethnicity data.</p> <p>iii). No documentation of the 2022 Covid-19 outbreaks could be located.</p>	<p>i)- ii). Ensure there is evidence of formal collation and analysis of infection control data which includes ethnicity.</p> <p>iii). Ensure documentation of all outbreaks remain on file and are accessible for reference.</p> <p>60 days</p>

<p>Criterion 6.1.6</p> <p>Health care and support workers shall be trained in least restrictive practice, safe practice, the use of restraint, alternative cultural-specific interventions, and de-escalation techniques within a culture of continuous learning.</p>	<p>PA Low</p>	<p>The manager, RN and caregivers were knowledgeable around restraint processes and their role in relation to documentation and monitoring of restraint; however, there was no evidence of restraint training being provided in the last two years.</p>	<p>The education records available during the audit did not evidence training around restraint in the last two years.</p>	<p>Ensure training sessions are held around restraint minimisation.</p> <p>90 days</p>
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## Specific results for criterion where a continuous improvement has been recorded

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

No data to display
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End of the report.