

Victoria Mt Eden Limited - Wesley Home and Care

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 Manatū Hauora (the Ministry of Health).

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

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

The specifics of this audit included:

Legal entity:	Victoria Mt Eden Limited
Premises audited:	Wesley Home and Care
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 17 September 2024 End date: 18 September 2024
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:	43

Executive summary of the audit

Introduction

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

- ō tātou motika | our rights
- hunga mahi me te hanganga | workforce and structure
- ngā huarahi ki te oranga | pathways to wellbeing
- te aro ki te tangata me te taiao 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 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

Wesley Home and Care is owned by Victoria Mt Eden Limited; two directors own the service along with another person who is a shareholder. The provider is certified to provide rest home services for up to 26 residents. On the first day of audit however, it was found that 43 residents were receiving care services at the facility. Whilst the previous (partial provisional) audit noted that there were 51 beds in the facility, certification was sought and granted for 26 at that time. A telephone conversation with HealthCert ensued; it was decided that the remaining beds in the service (25) would be assessed for suitability to provide rest home care. The 25 beds in the facility were, therefore, assessed and all have been assessed as suitable for the provision of rest home services. The service is managed by one of the directors who acts as the facility manager, supported by an experienced clinical manager, who is a registered nurse, providing clinical oversight of the facility.

This certification audit was conducted against the Ngā Paerewa Health and Disability Services Standard NZS 8134:2021 and the service provider's agreement with Health New Zealand – Te Whatu Ora (Te Whatu Ora). The audit process included review of residents' and staff files, observations and interviews with residents, whānau, the directors (two) and the shareholder of the facility, the clinical manager, staff, and a general practitioner. Residents and whānau interviewed were generally complimentary of the service and reported that the care provided was to a high standard.

Improvements required in the service relate to the service's responsibilities to Māori, Pasifika and tāngata whaikaha, complaints management processes, organisational policy and procedure, a quality and risk programme, resident and whānau input into services, staff and volunteer carer availability and management, staff and carer competencies, staff orientation and performance

appraisal, menu approval, fire extinguisher checking, engagement of Māori in partnership for cultural safe practice in infection prevention, the antimicrobial stewardship programme, infection surveillance reporting, laundry processes, and restraint reporting and review.

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 unattained and of moderate or high risk.

Wesley Home and Care provided an environment that supported residents' rights and culturally safe care; residents in the service are primarily of Asian descent. There were no Māori or Pasifika residents or staff in the service at the time of the audit. Staff and volunteer carers interviewed demonstrated an understanding of residents' rights, and care for residents showed that self-determination (mana motuhake) was respected. Personal identity, independence, privacy and dignity are respected and supported. Residents were safe from abuse.

Residents and whānau receive information in an easy-to-understand format and felt listened to and included when making decisions about care and treatment. Open communication is practised. Interpreter services are provided as needed. Whānau and legal representatives are involved in decision-making that complies with the law. Advance directives are followed wherever possible.

No complaints have been reported at the facility.

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 unattained and of moderate or high risk.
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The directors at Wesley Home and Care assume accountability for delivering a high-quality service.

Data for adverse events and infections is collected and compiled monthly.

A systematic approach to identify and deliver ongoing learning is in place.

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

Ngā huarahi ki te oranga | Pathways to wellbeing

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.		Some subsections applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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When people enter the service, a person-centred and whānau-centred approach is adopted. Relevant information is provided to the potential resident and their whānau.

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

Residents are supported to maintain and develop their interests and participate in meaningful community and social activities suitable to their ages and stages of life.

Medicines are safely managed and administered by staff who have been deemed competent to do so.

The food service is safely managed, with special cultural needs catered for.

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

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 partially attained and of medium or high risk and/or unattained and of low risk.
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The facility meets the needs of residents and was clean and well maintained. There was a current building warrant of fitness. Electrical equipment is tested as required. External areas meet the needs of residents and tāngata whaikaha. They are accessible, safe and provide shade and seating, and meet the leisure and recreation needs of residents.

Staff are trained in emergency procedures and attend regular fire drills. Staff, volunteer carers, 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

<p>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.</p>		<p>Some subsections applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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An experienced and trained infection control coordinator, who is a registered nurse, leads the infection prevention and control and antimicrobial stewardship programme.

The infection control coordinator is involved in procurement processes, any facility changes, and processes related to decontamination of any reusable devices.

Staff demonstrated good principles and practice around infection control. Staff, residents and whānau were familiar with the pandemic/infectious diseases response plan.

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

The environment supports both preventing infections and mitigating their transmission. Waste and hazardous substances were well managed. Effective cleaning and laundry services are in place.

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 partially attained and of medium or high risk and/or unattained and of low risk.
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There were two residents using restraints at the time of audit. Comprehensive assessment, approval, consent, evaluation and monitoring processes for restraint were in place. Restraint is used only when other interventions/strategies have been tried.

The restraint coordinator is the clinical manager of the service and is a registered nurse. Staff and volunteer carers interviewed demonstrated a sound knowledge and understanding of restraint monitoring.

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	8	0	5	8	4	0
Criteria	0	111	0	11	20	5	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	2	0	2	0
Criteria	0	12	4	12	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>	<p>UA Low</p>	<p>Wesley Home and Care (Wesley) has not developed appropriate policies, procedures and processes to embed and enact Te Tiriti o Waitangi in all aspects of its work (refer criterion 1.1.1); however, self-determination (mana motuhake) is respected for residents. Residents are cared for in a culturally safe manner and this was confirmed by residents and whānau interviewed. While staff and volunteer carers have had education on Te Tiriti o Waitangi and cultural safety in general, those interviewed were not able to describe what this meant to them in their practice.</p> <p>Strategies to actively recruit and retain a Māori health workforce across roles were not in place (refer criterion 1.1.3). At the time of audit, there were no staff or carers employed who identified as Māori and there were no Māori residents in the service. Most staff and volunteer carers identify with an Asian community (Vietnamese or Chinese), and this reflects the ethnicity of most of the residents in the service. Resident ethnicity is documented on admission.</p> <p>There are no Māori health plans in place. The service is not Māori-centred and there was no information relating to how the service would manage equity if Māori residents were admitted to the service (refer criterion 1.1.4). There was no signage in the facility in te reo</p>

		<p>Māori beyond a Code of Rights poster in English, te reo Māori, and New Zealand Sign Language (NZSL). The Code was also displayed in Cantonese and Mandarin.</p> <p>No partnerships have been established with iwi and/or other Māori organisations to support service integration, planning, equity approaches and support for Māori (refer criterion 1.1.5).</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> <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>	UA Low	<p>Wesley has not yet developed appropriate policies, procedures and processes to embed cultural safety for Pasifika in the organisation so that staff, and volunteer carers, can understand the worldviews of Pacific peoples, including their cultural and spiritual beliefs (refer criterion 1.2.1). A Māori and Pasifika Policy was reviewed on 1 September 2024: There were no models of care for Pasifika in the document (refer criterion 1.2.3), and no consideration of equity and efficient provision of health and disability services for Pasifika (refer criterion 1.2.2).</p> <p>Strategies to actively recruit and retain a Pasifika health workforce across roles were not in place (refer criterion 1.2.4). At the time of audit, there were no staff or volunteer carers employed who identified as Pasifika and there were no Pasifika residents in the service. Most staff identify with an Asian community (Vietnamese or Chinese), and this reflects the ethnicity of most of the residents in the service. Resident ethnicity is documented on admission.</p> <p>No partnerships have been established with Pasifika communities and/or organisations to support service planning, support, interventions, research, and evaluation of the health and wellbeing of Pacific peoples to improve outcomes for Pasifika (refer criterion 1.2.5).</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-</p>	FA	<p>Staff and volunteer carers interviewed understood the requirements of the Code of Health and Disability Services Consumers' Rights (the Code) and were observed supporting residents in accordance with their wishes. Self-determination (mana motuhake) for residents was</p>

<p>determination). As service providers: We provide services and support to people in a way that upholds their rights and complies with legal requirements.</p>		<p>respected.</p> <p>Residents and whānau interviewed reported being made aware orally of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) and were provided with opportunities to discuss and clarify their rights through meetings with the clinical manager and the general practitioner.</p> <p>The Code of Rights is displayed in the staff room and at reception. However, there is no information to say what the facility will do to meet the rights of residents (refer criterion 2.2.4). The posters were displayed in Chinese/Cantonese, Chinese/Mandarin, English, Māori and New Zealand Sign Language (NZSL).</p>
<p>Subsection 1.4: I am treated with respect</p> <p>The People: I can be who I am when I am treated with dignity and respect.</p> <p>Te Tiriti: Service providers commit to Māori mana motuhake.</p> <p>As service providers: We provide services and support to people in a way that is inclusive and respects their identity and their experiences.</p>	<p>PA Low</p>	<p>The service supports residents in a way that is inclusive and respects their identity and experiences. Residents and whānau, including tāngata whaikaha (people with disabilities), confirmed that they received services in a manner that has regard for their dignity, gender, privacy, sexual orientation, spirituality and choices.</p> <p>Staff and volunteer carers were observed to maintain privacy throughout the audit. All residents have a private room. Several of the adjoining rooms were occupied by Chinese married couples. Shared ensuites can be used for same-sex residents only, or for married couples. Residents interviewed said they consented to share with another person.</p> <p>Te reo Māori and tikanga Māori are not actively promoted throughout the organisation (refer criteria 1.1.1 and 1.4.4). The cultural needs of tāngata whaikaha are responded to by the service. Wesley has no Māori residents and does not have partnerships with iwi or community Māori organisations to enable participation in te ao Māori if Māori were to be admitted to the service (refer criterion 1.1.5); however, cultural festivities relevant to te ao Māori had been promoted within the service with events such as Matariki Day celebrations (residents were taken to Mt Eden Library to share the celebration with the wider community).</p> <p>Staff have undertaken training in Te Tiriti o Waitangi and cultural</p>

		safety but did not have a full understanding of how to apply these in their daily work (refer criterion 1.1.1).
<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>	PA Low	<p>Staff and volunteer carers understood the service's policy on abuse and neglect, including what to do should there be any signs. There were no examples of discrimination, coercion or harassment identified during the audit through staff and/or resident or whānau interviews, or in documentation reviewed.</p> <p>Management have requested that residents' property be labelled. Residents reported that their property is respected. Residents are advised not to carry cash or jewellery, but if they chose to do so, this was respected.</p> <p>Professional boundaries are maintained by staff and volunteer carers. Staff and volunteer carers interviewed felt comfortable in raising any concerns in relation to institutional and systemic racism and reported that any concerns would be acted upon. While a strengths-based and holistic model of care was evident and was used to ensure the needs of the culturally diverse residents were met, these did not include specific models of care for Māori or Pasifika (refer criterion 1.5.6). There are currently no Māori residents in the service.</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 people who use our services and effectively communicate with them about their choices.</p>	FA	<p>Residents and whānau reported that communication was open and effective, and they felt listened to by the clinical team. Information was provided in an easy-to-understand format. Changes to residents' health status were communicated to whānau in a timely manner, and this was confirmed through documentation reviewed and interviews with whānau. Where other agencies were involved in care, communication had occurred.</p> <p>Examples of open communication were evident following adverse events. These were sighted in the progress notes, family meetings, allied health professionals, specialist and doctors' notes.</p> <p>Staff and volunteer carers knew how to access interpreter services, if</p>

		<p>required. Several staff and volunteer carers spoke Vietnamese, Chinese Mandarin, Chinese Cantonese and English and were able to relate well to the residents and their whānau.</p> <p>Electronic tablets were noted to be in use for residents with aphasia to enable communication with staff and volunteer carers.</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>	PA Low	<p>Residents and/or their legal representative are provided with the information necessary to make informed decisions. They felt empowered to actively participate in decision-making related to the care of the residents. With the consent of the resident, whānau were included in decision-making.</p> <p>The clinical manager, staff and volunteer carers interviewed understood the principles and practice of informed consent, but not in relation to tikanga (refer 1.7.9). Medical, nursing and progress notes provided evidence of informed consent and the involvement of whānau in resident care. With English being a second language for many of the residents, the medical and nursing staff were particularly careful to ensure whānau were involved, and whānau acted as interpreter for residents if required.</p> <p>Advance care planning, establishing and documenting Enduring Power of Attorney (EPOA) requirements and processes for residents unable to consent were documented, as relevant, in the resident's record.</p> <p>An interpreter was used on the days of the audit to interview residents and whānau for whom English was a second language.</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</p>	UA High	<p>There is no system in place to easily allow residents and their whānau to make a complaint (refer criterion 1.8.1). There was no complaints management policy or procedure in place for the service. No complaints forms were readily available in the facility and no information (such as health and disability advocacy information) was available to support someone to make a complaint if they wished to do so (refer criterion 1.8.2).</p>

<p>system in place to easily receive and resolve or escalate complaints in a manner that leads to quality improvement.</p>		<p>Resident/whānau interviewed reported complaints in relation to staffing (the number of staff and the conditions of employment related to them) and the meal service during the audit; these had not been raised formally but there was evidence that the facility manager was aware of the meal issue as photographs were being taken of meals. The complaints had not been documented beyond photograph taking prior to service.</p> <p>There was no documentation of resident meetings which may have allowed residents and their whānau to express any concerns; two were reported by the facility manager to have been held in 2024, but there were no minutes from those meetings. When asked, the facility manager said that they did not take minutes as these were informal and language differences made it difficult. There had been no attempt to try to mitigate the language risk. Residents interviewed reported that they would like to have meetings to discuss any issues they may be having. No resident satisfaction surveys have been undertaken.</p> <p>There are no policies, procedures or processes to ensure the complaints process would work equitably for Māori. Senior and managerial staff did not understand the concept of tikanga related to complaints from Māori (refer criterion 1.8.5).</p> <p>There have been no complaints received from external sources.</p>
<p>Subsection 2.1: Governance</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 High</p>	<p>The directors and shareholder are the governance group for Wesley; they assume accountability for delivering a high-quality service to the resident communities served.</p> <p>Wesley has no policy or procedures in place to make sure that legislative, contractual and regulatory requirements are encapsulated in policy for staff to refer to (refer criterion 2.1.1). One of the directors advised that external advice would be sought if required.</p> <p>The purpose, values, direction, scope and goals of the organisation have not been defined in any documentation (refer criterion 2.1.2).</p> <p>There is an experienced and suitably qualified clinical manager, who is a registered nurse, managing clinical services in a part-time</p>

	<p>capacity; however, there is only on-call backup available for the clinical manager (refer criteria 2.3.1). The clinical manager is efficient in dealing with day-to-day clinical management for residents in the service, including timely interRAI assessments and care planning. The clinical manager works effectively with the general practitioner and other health care practitioners (e.g., hospital services, services for tāngata whaikaha, physiotherapy) in a multidisciplinary fashion. This was evidenced through resident documentation and confirmed by the general practitioner at interview. The clinical manager also works as the facility manager/registered nurse at another (nearby) facility owned by one of the directors of Wesley.</p> <p>The facility manager is inexperienced in the management of an aged care facility and was unaware of the requirements around the management of all the contractual, legislative and regulatory requirements for managing a residential aged care facility (refer criterion 2.1.3).</p> <p>There was no quality and risk programme available at the facility that had been approved by the governing body (refer criterion 2.1.4).</p> <p>There are no policies that describe how the service provider is able to demonstrate how they will improve outcomes and achieve equity for Māori (refer criterion 2.1.5). While there were no specific policies in place that refer to the achievement of outcomes and equity for tāngata whaikaha and the removal of barriers to address equitable service delivery, residents with disabilities (tāngata whaikaha) were observed to be having their disability needs met during the audit, and barriers to equity were identified for residents during the care planning process. Environmentally, there was evidence that the facility addresses barriers for residents (e.g., ramps for access around the facility, handrails, large televisions, electronic tablets for communication, residents wearing hearing aids).</p> <p>Participation in service delivery was limited; there were no documented meetings with residents, or resident satisfaction surveys, and no accessible complaints processes in place. During the audit, managers, staff and volunteer carers were observed to be engaging with residents on a one-to-one basis, and there was evidence of input from residents and their whānau in care planning</p>
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		<p>(refer criterion 2.1.8).</p> <p>There is no input from Māori into the service (refer criterion 2.1.9), and the governance group was not able to demonstrate expertise in Te Tiriti o Waitangi, health equity or cultural safety (refer criterion 2.1.10).</p> <p>The service holds contracts with Te Whatu Ora to provide rest home level care for 23 residents under the age-related residential care contract (ARRC). Forty-three (43) residents were receiving rest home services at the time of audit. A previous (partial provisional) audit conducted in 2023 noted that there were 51 beds in the service at that time; the service had applied for certification for 23. Following a discussion with HealthCert (Manatū Hauora), it was decided that the remaining beds up to the 51-bed capacity (28 beds) would be assessed for their appropriateness in delivering the required care. All beds are single rooms and were assessed as being appropriate for the delivery of rest home care.</p>
<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 High</p>	<p>The organisation does not have a planned quality and risk system in place that reflects the principles of continuous quality improvement. There is little participation by the workforce (adverse event documentation) and people using the service (care planning) (refer criterion 2.2.1). Residents and whānau have opportunities to contribute to quality improvement only through the care planning processes. Staff and volunteer carers have little opportunity to contribute, as staff meetings do not show evidence of the reporting of key performance indicators and goal setting in relation to these.</p> <p>There is no framework in place based on quality and risk, to improve service delivery (refer criterion 2.2.2). The clinical manager was, however, able to describe processes for the identification, documentation, monitoring, review and reporting of resident risks. Information on adverse events and infections is collected by the clinical manager and collated monthly. Monthly numbers are given to the facility manager, but there is no further analysis of adverse events and infections, these are not trended over time, and there was no evidence of formal reporting to either governance (though</p>

		<p>they are onsite frequently), staff or volunteer carers (refer criterion 2.2.3). Staff and volunteer carers document adverse and near miss events in line with the National Adverse Events Reporting Policy. A sample of incidents forms reviewed showed these were fully completed; however, not all residents who required follow-up interventions had these completed (refer criterion 2.2.5). In addition to this, staff and carers do not receive information related to adverse events or infections to inform quality outcomes and risk mitigation processes and to improve the delivery of care (refer criterion 2.2.3). Critical analysis of practices and systems using ethnicity data to identify organisational risks and opportunities and possible inequities in the service do not take place (refer criteria 2.2.4 and 2.2.8).</p> <p>Delivering high-quality care to Māori residents is difficult, as there are no fit-for-purpose documents in place to support staff and volunteer carers; education/training for staff did not include tikanga (refer 2.2.7).</p> <p>The clinical manager understood essential notification reporting requirements, including the reporting requirements to Te Tāhū Hauora - Health Quality and Safety Commission for all severity assessment code (SAC) reporting at SAC1 and SAC2, as well as pressure injury at stage 3 and above. One of the directors was aware of HealthCert (Manatū Hauora) and Te Tāhū Hauora reporting requirements, but the other director, who works as the facility manager, did not (refer criterion 2.1.3). No reporting to either HealthCert, Te Tāhū Hauora or any other body (e.g., regional public health) has been required to date.</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. 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</p>	<p>PA High</p>	<p>The service does not have a documented process for determining staffing levels and skill mixes to provide culturally and clinically safe care, however care staff/volunteer carers numbers had increased as residents were admitted so the service (see subsection 4.1). Staff and caregivers are onsite, 24 hours a day, seven days a week (24/7) to provide care for residents, but not all carers working in the service are employed (refer criterion 2.3.1); there are insufficient employed staff on duty. The majority of carers work at Wesley in a voluntary capacity. There is not always an employed staff member on duty</p>

<p>services.</p>	<p>(refer criterion 2.3.1).</p> <p>A multidisciplinary team (MDT) approach ensures all aspects of care delivery are met. The clinical manager, however, is often required to work beyond the number of hours employed for in order for this to be achieved (refer criterion 2.3.1). Those providing care reported there were adequate staff and carers to complete the work allocated to them. At interview, two whānau of residents raised the issue of staffing, one in relation to the number of staff and the other in terms of working conditions for staff. At least one carer on duty has a current first aid certificate.</p> <p>There is an employment process in place for staff employed by the service that includes collecting information on their skills, qualifications and experience. Voluntary carers have no records related to their skill sets or qualifications (refer 2.3.2). Most staff (with the exception of the clinical manager and other support staff) work across different sections of the service, for example, care staff may be involved in cleaning, laundry, kitchen and activities work, and kitchen staff may be involved in care work (one of the chefs works as a medication competent caregiver).</p> <p>Continuing education is planned on an annual basis. An education/training programme is in place. While this includes most of the mandatory training requirements, it does not include sufficient education in relation to Māori, and the education/training programme has not been well attended. There is no overarching process in place to document education/training undertaken by staff, beyond education signing sheets (refer criteria 2.3.4 and 2.3.7).</p> <p>There are no established processes for competencies assessment, except in relation to medication management (for staff/carers who are administering medication) and fire and emergency management. Some other competencies have been completed by some other staff/carers, such as moving and handling, restraint management, and food handling). There is no overarching process in place to record these, and the requirements do not cover all of the competencies required for all staff/carers (refer criterion 2.3.3).</p> <p>Training and support for people using the service is managed primarily through the clinical manager and general practitioner.</p>
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<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 needs of Māori.</p> <p>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>PA High</p>	<p>Wesley has no human resources policies and procedures in place to ensure staff are recruited and managed using good employment practice and legislation. There is an employment process in place for staff employed by the service, but not for people working as volunteer carers. Voluntary carers have no personnel records, including visa records (refer criterion 2.4.1).</p> <p>Position descriptions for staff do not always correspond to the roles that they are undertaking. There was no evidence that volunteer carers have the skills and knowledge required for their work, nor documentation of how accountabilities, responsibilities, authority or functions will be achieved (refer criterion 2.4.2).</p> <p>Professional qualifications for health care professionals had been validated during recruitment and then checked and documented annually.</p> <p>Orientation was documented in six employed staff files reviewed; however, the programme does not cover the essential components of the service, and there are no records for volunteer carers (refer criterion 2.4.4).</p> <p>Opportunities to discuss and review performance at defined intervals could not be verified in all files across the seven files sighted (refer criterion 2.4.5).</p> <p>Information that is collected for staff employed includes ethnicity data. Where information was available it was accurately recorded,</p>

		<p>held confidentially and used in line with the Health Information Standards Organisation (HISO) requirements. Ethnicity information is used to ensure residents have access to staff/volunteer carers who speak their language.</p> <p>Staff confirmed that they had the opportunity to debrief on a one-to-one basis following any incidents, to promote their wellbeing.</p>
<p>Subsection 2.5: Information</p> <p>The people: Service providers manage my information sensitively and in accordance with my wishes.</p> <p>Te Tiriti: Service providers collect, store, and use quality ethnicity data in order to achieve Māori health equity.</p> <p>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.</p>	<p>UA High</p>	<p>Wesley Care had no policies and procedures in place to describe how it will comply with relevant legislation, health information standards, privacy, or professional guidelines (refer criterion 2.5.1).</p> <p>Some resident information was held electronically and was username and password protected, and information that was paper based was held securely. Staff records were paper-based and also held securely.</p> <p>Records were held securely and only available to authorised users. Access to resident and staff information was limited dependent on the role of the person in the service. Data collected included ethnicity data for residents and staff.</p> <p>Residents' files reviewed were integrated. All the necessary demographic, personal, clinical and health information required was fully completed in the residents' files sampled for review. Clinical notes were current, integrated and legible, and met current documentation standards. Consent was sighted for data collection.</p> <p>Files for residents and staff were being held safely and securely for the required period before being destroyed. There were no records sighted for volunteer carers.</p> <p>No personal or private resident information was on public display during the audit.</p> <p>Wesley Care is not responsible for the National Health Index registration of people receiving services.</p>

<p>Subsection 3.1: Entry and declining entry</p> <p>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.</p> <p>Te Tiriti: Service providers work proactively to eliminate inequities between Māori and non-Māori by ensuring fair access to quality care.</p> <p>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.</p>	<p>PA Low</p>	<p>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) agency. Files reviewed met contractual requirements. Residents enter the service based on documented entry criteria available to the community and understood by the accepting clinical manager. The entry process meets the needs of residents. Whānau interviewed were satisfied with the admission process and the information that had been made available to them on admission. An admission agreement which defined the service, and any fees, was sighted as signed by the resident.</p> <p>The facility had an active website that it directed whānau to for facility information. Most of the information was provided orally when whānau called the facility or during a tour of the facility.</p> <p>No prospective resident has been declined entry into the service; however, data related to the entry and decline process is not documented and analysed, including decline rates for Māori (refer criterion 3.1.5). There was evidence that when a resident had been inappropriately placed following admission, they were referred to Te Whatu Ora for reassessment and alternative placement.</p> <p>The service has not developed partnerships with Māori communities and organisations (refer criterion 3.1.6). Staff interviewed said that, if Māori were to enter the service, they would support Māori and their whānau. The facility aims to develop partnerships with the Chinese and other Asian communities and is providing support for them and their whānau when entering the service.</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</p>	<p>FA</p>	<p>The multidisciplinary team works in partnership with the resident and whānau to support wellbeing. A care plan is developed by the clinical manager following a comprehensive assessment, including consideration of the person's lived experience, cultural needs, values and beliefs, and which considers wider service integration, where required. Early warning signs and risks, with a focus on prevention or escalation for appropriate interventions, are recorded.</p> <p>Assessment is based on a range of clinical assessments and</p>

<p>whānau to support wellbeing.</p>		<p>includes resident and whānau input (as applicable). Timeframes for the initial assessment, medical assessment, initial care plan, interRAI, long-term care plan and review timeframes met contractual requirements. The clinical manager understood and supported residents and their whānau to identify their own pae ora outcomes in their care plan. This was verified by sampling seven residents' records, from interviews with the clinical manager, general practitioner, seven people receiving services and three whānau.</p> <p>Management of any specific medical conditions was well documented, with evidence of systematic monitoring and regular evaluation of responses to planned care, including the use of a range of outcome measures. Where progress is different to that expected, changes are made to the care plan in collaboration with the resident and/or whānau. Residents and whānau confirmed active involvement in the process.</p> <p>Tāngata whaikaha and their whānau interviewed reported that they participated in service development through undocumented residents' meetings (refer criterion 2.1.8), one-on-one discussion with management, and care planning. Examples of choices and control over service delivery were discussed with staff/volunteer carers, tāngata whaikaha and whānau. Tāngata whaikaha and their whānau can independently access information.</p> <p>The clinical staff understood the Māori constructs of oranga, and should Māori access the service they would ensure the support to achieve their pae ora outcomes would be clearly documented, communicated and understood. There was evidence this practice was embedded for all residents irrespective of ethnicity.</p> <p>The clinical manager was utilising clinical policies and procedures from another facility owned by one of the directors to guide practice; however, the policies were last updated in 2019 and were not specific to the Wesley service (refer criterion 2.1.1).</p>
<p>Subsection 3.3: Individualised activities The people: I participate in what matters to me in a way that I like.</p>	<p>FA</p>	<p>An activities programme is in place which supports residents to maintain and develop their interests and was suitable for their age and stage of life. While there was no 'calendar' of activities in the</p>

<p>Te Tiriti: Service providers support Māori community initiatives and activities that promote whanaungatanga.</p> <p>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.</p>		<p>facility, the programme was planned and facilitated to develop and enhance people’s strengths, skills, resources, and interests, and was responsive to their identity (both NZ European and Chinese/Vietnamese). Feedback on the programme is provided orally. Those interviewed confirmed they found the programme meets their needs. Two whānau interviewed reported that they would like to see more activities. One resident interviewed would like a calendar of activities, so they do not miss activities of interest.</p> <p>Activity assessments and plans identified individual interests and considered the person’s identity. Individual and group activities reflected residents’ goals and interests, ordinary patterns of life, and included normal community activities. There were opportunities to celebrate residents’ birthdays, special occasions such as the autumn festival, Matariki and Christmas. Outings were regular, with a Mt Eden library visit each week. Residents were encouraged to join the morning video exercise programme and dance and music activities. Community activities met the needs of the residents.</p> <p>The facility was decorated with floral displays which complemented the facility. The flower-themed concept was reviewed three monthly. There is a church service weekly, and residents attended local church services, including culturally supported services in their own language. The chaplain was visiting the facility on the day of the audit. Residents had access to dedicated themed rooms for Mahjong and therapeutic massage. There was a piano available in the lounge and residents were observed enjoying the instrument on several occasions.</p> <p>Opportunities for residents to engage in in te ao Māori had been facilitated (refer subsection 1.4).</p>
<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</p>	<p>FA</p>	<p>The medication management policy was current and in line with the Medicines Care Guide for Residential Aged Care. A safe system for medicine management (using an electronic system) was observed on the day of audit. One resident was on a manual system with a separate signing sheet as they wished to maintain their general practitioner. All staff who administer medicines were assessed as</p>

<p>and blood products in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>competent to perform the function they managed.</p> <p>Medication reconciliation occurs. All medications sighted were within current use-by dates.</p> <p>Medicines are stored safely, including controlled drugs. The required stock checks had been completed. Medicines stored were within the recommended temperature range.</p> <p>Prescribing practices meet requirements. Medicine-related allergies or sensitivities were recorded, and any adverse events responded to appropriately. Over-the-counter medication and supplements were considered by the prescriber as part of the person's medication. The required three-monthly general practitioner review was consistently recorded on the medicine chart. Standing orders are used, were limited, complied with guidelines and were signed and dated 21 February 2024.</p> <p>Self-administration of medication is facilitated and managed safely, if required. There were currently no residents self-medicating. Residents, and their whānau, are supported to understand their medications. There were no Māori in the service during the audit, but the clinical manager and general practitioner were confident they could provide appropriate support, advice and treatment for Māori should this be required in the future. Where there are difficulties accessing medications, this is identified, and support provided.</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>A food service is provided for residents; however, the menu has not been reviewed by an appropriately qualified person (such as a dietitian) to assess its compliance with recognised nutritional guidelines for people using the services (refer criterion 3.5.7).</p> <p>All aspects of food management comply with current legislation and guidelines. The service operates with an approved food safety plan and registration; the food control plan expires on 13 August 2025.</p> <p>Each resident has a nutritional assessment on admission to the facility and copies of these assessments were sighted as being available to all kitchen staff. Personal food preferences, any special diets and modified texture requirements are accommodated in the</p>

		<p>daily meal plan. There are no menu options available that are culturally specific to te ao Māori (refer criterion 3.5.7). Each resident has a choice of Chinese/Vietnamese-inspired food or Pakeha-styled meals at each delivery. The menu, originally in English, was translated for staff use into Vietnamese and was displayed in the kitchen facilities.</p> <p>There are minimal processed fruits and vegetables and ready-to-eat snacks. Residents much prefer freshly prepared fruit, vegetables and snacks. The facility prepares fresh bread each day for residents' use. Residents were given sufficient time to eat their meals in an unhurried fashion and those requiring assistance had this provided with dignity. There are three dining rooms available for residents' use.</p> <p>There was no evidence of resident satisfaction with meals through satisfaction surveys or resident meeting minutes (refer criterion 2.1.8). Residents interviewed were reasonably satisfied with the meals. One family member interviewed understood that Kiwi residents were sometimes unhappy with the meals.</p>
<p>Subsection 3.6: Transition, transfer, and discharge</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>	FA	<p>Transfer or discharge from the service is planned and managed safely, with coordination between services and in collaboration with the resident and their whānau. Risks and current support needs are identified and managed. Options to access other health and disability services and social/cultural supports are discussed, where appropriate. The transfer process includes the use of the yellow envelope system, including a transfer form and the front page of the current interRAI. All senior staff are aware of the process and instructions are available in the staff room. Whānau reported being kept well informed during the transfer of their relative.</p>
<p>Subsection 4.1: The facility</p> <p>The people: I feel the environment is designed in a way that is safe</p>	FA	<p>Appropriate systems are in place to ensure the physical environment and facilities (internal and external) are fit for their purpose, well maintained and that they meet legislative requirements. A building</p>

<p>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>warrant if fitness was displayed with an expiry date of 4 October 2024. There are external areas within the facility for leisure and recreation activities with appropriate seating and shade. Ramps are in place where there are changes in ground levels.</p> <p>The environment was comfortable and accessible, promoting independence and safe mobility and minimising risk of harm. Personalised equipment was available for residents with disabilities to meet their needs, and residents were observed to be safely using these. Spaces are culturally inclusive and suited the needs of the resident groups, including tāngata whaikaha. Lounge and dining facilities meet the needs of residents, and these are also used for activities. Wi-Fi was available for residents and whānau to use, and access to equipment needed by tāngata whaikaha enabled (e.g., electronic tablet uses for aphasic residents).</p> <p>All residents have their own room, and all have a window allowing for natural light, with safety catches for security. The provider is currently certified to provide rest home services for up to 26 residents. On the first day of audit however, it was found that 43 residents were receiving care services at the facility. Whilst the previous (partial provisional) audit noted that there were 51 beds in the facility, certification was sought and granted for 26 at that time. Following a telephone conversation with HealthCert, it was decided that the remaining beds in the service (25) would be assessed for suitability to provide rest home care. The 25 beds in the facility were, therefore, assessed. All are of the same configuration/size as the rooms currently being used to provide rest home services and all are suitable for the provision of rest home services. Rooms were of a good size and personalised according to the residents' preferences. Care staff/volunteer carer numbers increased in relation to the increase in residents in the facility (refer subsection 2.3.1).</p> <p>The facility is heated through radiators from a boiler, and this can be adjusted depending on seasonality and outside temperature. Space is available for the storage and charging of electronic mobility aids.</p> <p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility, including for staff and visitors. Shared bathrooms are in use only for married couples or people of the same sex, with consent. All rooms, bathrooms and communal areas have</p>
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		<p>appropriately situated call bells, and these were noted to be near to residents when they were in their rooms.</p> <p>A planned maintenance schedule includes electrical testing and tagging, resident equipment checks, and calibrations of clinical equipment. Monthly hot water tests are completed for resident areas; these were sighted and adjusted using tempering valves as required.</p> <p>The service currently has no plans for changes to the building. One of the directors was aware of the requirement to consult and co-design with Māori during the design process should this be envisaged in the future.</p> <p>Residents and whānau were happy with the environment, including heating and ventilation, natural light, privacy, and maintenance. Care staff interviewed stated they have adequate equipment to safely deliver care for residents.</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>The fire evacuation plan was approved by Fire and Emergency New Zealand (FENZ) on 9 February 2024. The requirements of the fire and emergency scheme are reflected in the facility's fire and emergency management plan. A fire evacuation drill is held six-monthly; the most recent drill was on 18 July 2024.</p> <p>While there were no specific policies and procedures, a fire and emergency plan which includes disaster and civil defence plans directs the facility in its preparation for emergencies and described the procedures to be followed. The plan identifies risks and how to manage them. Evidence of relevant information and training was sighted in records for 23 staff. The facility is sprinklered and smoke alarmed; these are checked monthly by an external contractor. Fire extinguishers are available in the facility; none had evidence of safety checking (refer criterion 4.2.3). A fire blanket was available in the kitchen. Staff/volunteer carers interviewed knew what to do in an emergency.</p> <p>Adequate supplies for use in the event of a civil defence emergency meet The National Emergency Management Agency recommendations for the region; these include water supplies, food,</p>

		<p>and equipment to cook and service food and water. Cooking is through tanked gas supplies through the main kitchen.</p> <p>Staff/volunteer carers can provide a level of first aid relevant to the risks for the type of service provided. There was a first aid certified staff member or volunteer carer on duty 24/7 on the rosters reviewed.</p> <p>Call bells alert staff to residents requiring assistance. Residents and whānau reported staff respond promptly to call bells, and this was observed during the audit. Formal call bell monitoring does not take place as no internal auditing processes are in place (refer criterion 2.2.3).</p> <p>Information on emergency and security arrangements is provided verbally to residents and their whānau on entry to the service and this was confirmed by residents and whānau interviewed. The facility has overnight 'lock-up' procedures which allow for emergency egress. Closed-circuit television (CCTV) cameras are in use externally to the facility, in corridors and in the medication room, with warning signs of their use in place. The use of CCTV is included in resident admission agreements. All staff were noted to be wearing uniforms and name badges during the audit.</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>	<p>PA Moderate</p>	<p>There are no strategic plans in place, therefore infection prevention (IP) and antimicrobial stewardship (AMS) programmes are not integral to any strategic planning or any other documentation (refer criterion 5.1.1).</p> <p>Expertise and advice are available to the facility through Te Whatu Ora and Regional Public Health, this is on an 'as needed' basis and this does not assist in defining the strategic direction of the organisation (refer criterion 5.1.2).</p> <p>Information on infection is collected and aggregated monthly and this information is delivered to the facility manager. There is no further aggregation of the information over time to detect infection patterns (refer criterion 5.1.2), and no data to support a concerted effort to reduce the use of antimicrobials.</p>

		<p>While antibiotic use is monitored and managed by the clinical manager in consultation with the general practitioner, there is no antimicrobial strategy in place. Directors (which includes the facility manager) were aware of any significant infection events by virtue of them being on site most days.</p> <p>Infection in relation to clinical practice was well managed by the clinical manager in consultation with the general practitioner and, where necessary, with clinical nurse specialists at Te Whatu Ora.</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. 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.</p>	<p>PA Moderate</p>	<p>The clinical manager is the infection prevention and control coordinator (IPCC) for the service. They are responsible for overseeing and implementing the IP programme. The IPCC is a registered nurse and has appropriate skills, knowledge and qualifications for the role and confirmed access to the necessary resources and support. Their advice would be sought when making decisions around procurement relevant to care delivery, design of any new building or facility changes, and policies. The clinical manager reports infection rates to the governance group.</p> <p>There are no policies and procedures at Wesley to guide practice (refer criterion 5.2.2), including those required under the provider's contract with Te Whatu Ora. The clinical manager uses the policies and procedures of another facility to guide safe practice (refer criterion 2.1.1); infection rates are low in the facility. Cultural advice is accessed where appropriate.</p> <p>Staff and volunteer carers were familiar with infection control principles through ongoing education (refer criterion 2.3.4) and were observed to follow these correctly. Residents and their whānau are educated about infection prevention in a manner that meets their needs. Educational resources, such as handwashing, are available in te reo Māori.</p> <p>A pandemic/infectious diseases response plan is documented and has been tested; again, this is the property of another facility, but it guides practice at Wesley. There are sufficient resources and personal protective equipment (PPE) available, and staff/volunteer</p>

		<p>carers have been trained in its use.</p> <p>There were no written policies on decontamination of reusable medical devices and no audit process in place (refer criteria 2.1.1 and 2.2.3); however, staff and volunteer carers were familiar with processes for the decontamination of reusable medical devices and there was evidence of these being appropriately decontaminated and reprocessed. Single-use medical devices are not reused.</p> <p>Wesley has no partnerships with Māori for the protection of culturally safe practice in IP, to acknowledge the spirit of Te Tiriti o Waitangi (refer criterion 5.2.13).</p>
<p>Subsection 5.3: Antimicrobial stewardship (AMS) programme and implementation</p> <p>The people: I trust that my service provider is committed to responsible antimicrobial use.</p> <p>Te Tiriti: The antimicrobial stewardship programme is culturally safe and easy to access, and messages are clear and relevant.</p> <p>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.</p>	<p>PA Moderate</p>	<p>The AMS programme in place is personalised to another facility owned by one of the Wesley directors and managed part-time by the Wesley clinical manager; it has not been approved by Wesley governance (refer criterion 5.3.1). There are no relevant policies and procedures in place specific to Wesley (refer criterion 5.3.2). Responsible use of antimicrobials is, however, promoted. The effectiveness of the AMS programme is evaluated by monitoring antimicrobial use and identifying areas for improvement.</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>Surveillance of health care-associated infections (HAIs) is appropriate to those recommended for the type of services offered and is in line with managing risk. Whilst there was no policy in relation to HAIs, standardised definitions were in use by the service in relation to HAIs.</p> <p>Monthly surveillance data is collated, but this is not analysed to identify any trends, possible causative factors or required actions. There is no documentation to record that the results of the surveillance programme are shared with staff/volunteer carers (refer criteria 5.4.4); the numbers of infections are reported to the facility manager, who is part of the governance group. There have been no infection outbreaks. In May 2024, there were four individual cases of</p>

		<p>COVID-19 that were well managed with no further spread through the facility. One resident has been identified with a history of MRSA positive and this is managed by standard precautions.</p> <p>Communication between service providers and residents that are experiencing a HAI is culturally safe. Ethnicity data is collected and associated with any HAIs in the facility.</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 antimicrobial-resistant organisms.</p>	<p>PA Moderate</p>	<p>A clean and hygienic environment supports prevention of infection and mitigation of transmission of antimicrobial-resistant organisms.</p> <p>Staff follow good practice processes for the management of waste and infectious and hazardous substances; no written policy was supplied (refer criterion 5.5.1). A hazard management plan is in place which uses a risk-based approach to hazards and includes hazards associated with chemical use. Chemicals were stored safely.</p> <p>There are safe and effective cleaning processes appropriate to the size and scope of the service, but there is no written policy in place to guide practice (refer criterion 2.2.1).</p> <p>Despite there being no policy in place, laundry services are effective. There is, however, no clear separation of clean and dirty laundry in the laundry area (refer criterion 5.5.4).</p> <p>The IPCC has oversight of the environment to facilitate the prevention of infection and mitigation of transmission of antimicrobial-resistant organisms. Staff/volunteer carers involved have completed education/training relevant to their role and were observed to carry out duties safely. The IPCC has no job description that describes responsibilities relating to oversight of the facility testing and monitoring of the built environment (refer criterion 5.5.5). There were no audits of the cleaning or laundry service (refer criterion 2.2.4).</p> <p>Residents and whānau reported that residents' laundry is managed well, and the facility is kept clean and tidy. This was confirmed through observations.</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>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>PA Moderate</p>	<p>Restraint is used in the service. There is no documentation to support the facility working to eliminate restraint; there are no policies and procedures or any other strategic documents at Wesley that lay out the intentions of the governance group (refer criteria 6.1.1 and 6.1.5). Restraint has been stable since it was first put into place for two residents in March 2024. Adjustable high/low beds are available for residents who are at risk.</p> <p>The clinical manager, however, understood the processes related to restraint. At the time of audit, two residents were using four restraints (both were using bed rails and a lap belt). The directors of the service were aware of the restraint use; however, aggregated data in relation to restraint is not kept, restraint is not trended over time, and there is no policy in place that lays out an agreed strategy to ensure the health and safety of people and staff/volunteer carers (refer criterion 6.1.4).</p> <p>The clinical manager, in consultation with the general practitioner and residents' EPOA/whanau, is responsible for the approval of the use of restraints and the restraint processes. There are clear lines of accountability; all restraints have been approved.</p> <p>Restraint is part of the education/training programme for the facility. Education/training in restraint and management of behaviours that challenge was held in 2024, but only three staff underwent education/training in restraint management and four in management of behaviours that challenge (refer criterion 2.3.4), and nine completed a restraint competency (refer criterion 2.3.3).</p>
<p>Subsection 6.2: Safe restraint</p> <p>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.</p> <p>Te Tiriti: Service providers work in partnership with Māori to ensure that any form of restraint is always the last resort.</p> <p>As service providers: We consider least restrictive practices,</p>	<p>FA</p>	<p>When restraint is used, this is as a last resort when all alternatives have been explored. Assessments for the use of restraint, monitoring and evaluation were documented and included all requirements of the standard. Monitoring records were sighted and complete. Whānau confirmed their involvement. Access to advocacy is facilitated as necessary through the clinical manager and general practitioner.</p>

<p>implement de-escalation techniques and alternative interventions, and only use approved restraint as the last resort.</p>		<p>Monitoring of restraint is overseen by the clinical manager, who is the restraint coordinator, and takes into consideration the person's cultural, physical, psychological, and psychosocial needs, and addresses wairuatanga.</p> <p>A restraint register is maintained and reviewed by the clinical manager and general practitioner three-monthly. The register contained enough information to provide an auditable record, including all requirements of the standard.</p> <p>No emergency restraint has been used at the facility, therefore debrief has not been necessary. There have been no adverse events from the use of restraint in the facility.</p>
<p>Subsection 6.3: Quality review of restraint</p> <p>The people: I feel safe to share my experiences of restraint so I can influence least restrictive practice.</p> <p>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.</p> <p>As service providers: We maintain or are working towards a restraint-free environment by collecting, monitoring, and reviewing data and implementing improvement activities.</p>	<p>PA Low</p>	<p>Six-monthly review of restraint use has not yet been completed; this is because the review has only just become due. The use of restraint has remained stable since March 2024.</p>

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 1.1.1</p> <p>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).</p>	UA Low	<p>Te Tiriti o Waitangi is not embedded or enacted in the organisation. The Māori and Pasifika Policy sighted was reviewed on 1 September 2024. The policy is not fit for purpose and did not meet the requirements of the Ngā Paerewa Standard. The policy was not written in conjunction with Māori. There were no models of care for Māori in the document or any other documentation sighted. There were also no references to tikanga, Te Tiriti o Waitangi and the obligations thereof, health equity for Māori, or cultural safety for Māori. There were no Māori residents in the service; the staff and volunteer carers interviewed did not understand their</p>	<p>The service has not embedded or enacted Te Tiriti o Waitangi within its service, recognising the Crown’s partnership with Māori in the health sector. There are no effective policies and procedures in place outlining how the service will support Māori aspirations in the service should Māori be admitted. Staff and volunteer carers do not understand their obligations to Te Tiriti o Waitangi, or to Māori as tāngata whenua, or how to embed Te Tiriti of Waitangi principles into their practice.</p>	<p>Ensure there are policies and procedures in place related to culturally safe care for Māori, recognising Te Tiriti o Waitangi and support for Māori aspirations (including mana motuhake). Policy and procedures are to be written in conjunction with Māori. Provide evidence that further education/training has taken place to ensure staff and volunteer carers understand their obligations in relation to Te Tiriti o Waitangi, and for Māori as tāngata whenua, and how to embed Te Tiriti of Waitangi principles into the practice.</p> <p>180 days</p>

		obligations in relation to Te Tiriti o Waitangi, or to Māori as tāngata whenua, or how to embed Te Tiriti of Waitangi principles into their practice.		
<p>Criterion 1.1.3</p> <p>My service provider shall actively recruit and retain a Māori health workforce across all organisational roles.</p>	UA Low	There are no recruitment strategies in place, nor policies and/or strategic documentation, that outline the processes the organisation will use to recruit and retain Māori in the service. There were no staff employed, or volunteer carers in the service, who identified as Māori.	There are no recruitment strategies in place to recruit and retain Māori in the workforce and no documentation in relation to how this will be addressed by the service in any policy or strategic document.	<p>Provide evidence that recruitment strategies to recruit and retain Māori in the workforce are in place and that these are documented in policy and/or strategic documentation.</p> <p>180 days</p>
<p>Criterion 1.1.4</p> <p>To facilitate equity approaches, my service provider shall be Māori centred.</p>	UA Low	The service is not Māori-centred, and there were no policies or documentation to advise how the service would facilitate equity for Māori should they be admitted to the service. There was no Māori signage in the facility.	The service is not Māori-centred, nor are there any policies or documentation in place that promote equity for Māori.	<p>Provide evidence that the service is Māori-centred, with policies and documentation that show how the service will promote equity for Māori.</p> <p>180 days</p>
<p>Criterion 1.1.5</p> <p>My service provider shall work in partnership with iwi and Māori organisations within and beyond the health sector to allow for better service integration, planning, and support for Māori.</p>	UA Low	The service has no partnerships with iwi or Māori community organisations to enable better service integration, planning, and support for Māori. There were no Māori residents in the service.	The service has not developed any partnerships with iwi or Māori community organisations to enable better service integration, planning, and support for Māori.	<p>Provide evidence that partnerships with iwi or Māori community organisations have been established to enable better service integration, planning, and support for Māori.</p> <p>180 days</p>

<p>Criterion 1.2.1</p> <p>My service provider shall ensure cultural safety for Pacific peoples and that their worldviews, cultural, and spiritual beliefs are embraced.</p>	<p>UA Low</p>	<p>Cultural safety for Pasifika is not embedded or enacted in the service. The Māori and Pasifika policy was reviewed on 1 September 2024. The policy is not fit for purpose, it did not meet the needs of the Ngā Paerewa Standard. There are no models of care for Pasifika in the document, or references to Pasifika worldviews, or cultural and spiritual beliefs. There were no Pasifika in the service.</p>	<p>The service has not embedded or enacted cultural safety for Pasifika in the service. There were no effective policies and procedures in place outlining how the service will support Pasifika people. Staff and volunteer carers were not able to describe Pasifika worldviews, or cultural and spiritual beliefs related to Pacific peoples.</p>	<p>Ensure there are policies and procedures in place related to culturally safe and equitable care for Pasifika. Policy and procedures are to be written in conjunction with Pacific peoples. Provide evidence that staff and volunteer carers have had education/training to enable them to understand Pasifika worldviews, and cultural and spiritual beliefs related to Pacific peoples.</p> <p>180 days</p>
<p>Criterion 1.2.2</p> <p>My service provider shall focus on achieving equity and efficient provision of health and disability services for Pacific peoples.</p>	<p>UA Low</p>	<p>There are no policies/documentation in place to describe how the service will achieve equity and efficient provision of health and disability services for Pasifika. There were no Pasifika in the service. Staff and volunteer carers interviewed did not understand their obligations to promote health equity for Pasifika.</p>	<p>There are no policies/documentation in place to describe how the service will achieve equity and efficient provision of health and disability services for Pasifika. Staff and volunteer carers do not understand their obligations to health equity for Pasifika.</p>	<p>Ensure policies/documentation describe how the service will achieve equity and efficient provision of health and disability services for Pasifika. Provide evidence that the staff and volunteer carers have had education/training to enable them to understand their obligations to health equity for Pasifika.</p> <p>180 days</p>
<p>Criterion 1.2.3</p> <p>My service provider shall design a Pacific plan in partnership with Pacific communities underpinned by Pacific voices and Pacific models of care.</p>	<p>UA Low</p>	<p>While there were no Pasifika residents in the service, there is/are no model(s) of care documented for Pacific people in any policy or strategic document.</p>	<p>The organisation does not have an appropriate model of care documented for Pasifika to support service delivery for Pasifika.</p>	<p>Provide evidence that a model of care appropriate for Pasifika has been documented to support service delivery for Pasifika.</p> <p>180 days</p>

<p>Criterion 1.2.4</p> <p>My service provider shall actively recruit, train, and retain a holistic Pacific health and wellbeing workforce that is responsive to the Pacific population's health and disability needs. This will include Pacific peoples in leadership and training roles.</p>	<p>UA Low</p>	<p>There are no recruitment strategies in place, nor policies and/or strategic documentation, that outline the processes the organisation will use to recruit and retain Pasifika staff in the service. There were no staff employed or volunteer carers in the service who identified as Pasifika.</p>	<p>There are no recruitment strategies in place to recruit and retain Pasifika in the workforce and no documentation in relation to how this will be addressed by the service in any policy or strategic document.</p>	<p>Provide evidence that recruitment strategies to recruit and retain Pasifika in the workforce and in leadership and training positions are in place. These are to be documented in policy and/or strategic documentation.</p> <p>180 days</p>
<p>Criterion 1.2.5</p> <p>My service provider shall work in partnership with Pacific communities and organisations, within and beyond the health and disability sector, to enable better planning, support, interventions, research, and evaluation of the health and wellbeing of Pacific peoples to improve outcomes.</p>	<p>UA Low</p>	<p>The service has no partnerships with Pasifika communities or organisations to enable service integration, planning, or support for Pasifika with a view to improving health and wellbeing outcomes for Pasifika. There were no Pasifika residents in the service.</p>	<p>The service has not developed any partnerships with Pasifika communities or organisations to enable service integration, planning, or support for Pasifika with a view to improving health and wellbeing outcomes for Pasifika.</p>	<p>Provide evidence that partnerships with Pasifika communities or organisations have been established to enable better service integration, planning, and support for Pasifika, with a view to improving health and wellbeing outcomes for Pasifika.</p> <p>180 days</p>
<p>Criterion 1.4.4</p> <p>Te reo Māori and tikanga Māori shall be actively promoted throughout organisations and incorporated through all their activities.</p>	<p>PA Low</p>	<p>Te reo Māori and tikanga Māori are not actively promoted throughout the organisation. Policies and procedures to describe the responsibilities of staff in relation to te reo Māori and tikanga Māori are not documented and not practiced in the service. There is no te reo Māori signage in the facility beyond the combined poster for the Code in English, te reo Māori and NZSL. Staff and</p>	<p>Te reo Māori and tikanga Māori are not actively promoted throughout the organisation, nor incorporated through all their activities.</p>	<p>Provide evidence that te reo Māori and tikanga Māori are being actively promoted throughout the organisation and incorporated through all their activities.</p> <p>180 days</p>

		volunteer carers interviewed did not have a good understanding of their responsibilities should a resident identifying as Māori be admitted to the facility. There were no residents in the service who identified as Māori during the audit.		
<p>Criterion 1.5.6</p> <p>My service provider shall prioritise a strengths-based and holistic model ensuring wellbeing outcomes for Māori.</p>	PA Low	A strengths-based and holistic model of care was available for residents who came from Chinese or Vietnamese origins; this was encapsulated in a Chinese Culture Policy. There was, however, no overarching model of care relevant to people who were not Chinese, and none for Māori and Pasifika.	A strengths-based and holistic model ensuring wellbeing outcomes for Māori was not in place.	<p>Ensure that a strengths-based and holistic model ensuring wellbeing outcomes for Māori is in place.</p> <p>180 days</p>
<p>Criterion 1.7.9</p> <p>Service providers shall follow the appropriate best practice tikanga guidelines in relation to consent.</p>	PA Low	Staff and volunteer carers understood the principles and practice of informed consent and were noted to be caring for the residents in the way that they preferred; however, most staff and volunteer carers did not understand the concept of tikanga or how they would utilise tikanga to gain consent. There was no policy or procedure in place to guide them (refer criterion 1.1.1). Tikanga was not included in education/training in relation to Māori (refer criterion 2.2.7). There were no Māori residents in the	Most staff and volunteer carers did not understand the concept of tikanga in relation to consent.	<p>Ensure the education/training programme includes tikanga, including tikanga in relation to consent, and provide evidence that people working in the service have completed the education/training.</p> <p>180 days</p>

		service.		
<p>Criterion 1.8.1</p> <p>My right to make a complaint shall be understood, respected, and upheld by my service provider.</p>	UA High	<p>There are no policies and procedures available to guide staff and volunteer carers in the facility on the management of complaints. Staff and volunteer carers interviewed were unsure what they would do in relation to complaints other than “tell the manager or the clinical manager”. There were complaints around staffing, conditions of service, and meals, expressed during the audit.</p>	<p>The right to make a complaint is not understood, respected or upheld by the service provider. There is no free access to complaints information and staff and volunteer carers were unsure of the process to respond to the complaint despite education being provided in 2024.</p>	<p>Establish an appropriate complaints management process and provide evidence that this has been embedded in the service. Provide evidence that staff and volunteer carers have had further education in the complaints process and know what to do in the event that someone wishes to make a complaint.</p> <p>30 days</p>
<p>Criterion 1.8.2</p> <p>I shall be informed about and have easy access to a fair and responsive complaints process that is sensitive to, and respects, my values and beliefs.</p>	UA High	<p>No complaints forms or complaints information was readily available in the facility and no information (such as health and disability advocacy information) was available to support someone to make a complaint if they wished to do so. In addition to this, there was no ‘welcome’ information for residents and their whānau that outlined the complaints process and what to do if they wished to make a complaint.</p> <p>The facility manager advised that if anyone would like to complain, they would print a form for them. The form was in English only and many of the residents do not speak English. There were complaints around staffing,</p>	<p>There are no processes in place to allow residents, their whānau, or any other person to easily make a complaint. Where a complaint has been made, it has not been documented. Information on support for people wishing to make a complaint is not available in the facility. Staff and volunteer carers were unsure of the processes to be used for managing a complaint.</p>	<p>Provide evidence that there is a process in place to disseminate complaints information to residents and their whānau, including support for the complaints process. Provide evidence that complaints information, forms and support information is readily available in the facility and that complaints are documented. Provide evidence that the staff have had further education/training in the complaints process and know what to do in the event that someone wishes to make a complaint.</p> <p>30 days</p>

		<p>conditions of employment, and meals expressed by residents and their whānau during the audit. The facility manager had been aware of dissatisfaction around meals as the kitchen staff had been taking photographs of meals pre-service and sending these to the facility manager; the complaints had been verbal. There was no documentation in relation to meal complaints. The facility manager was unaware of the complaints expressed during the audit in relation to staffing and conditions of service as these had not been raised by the whānau interviewed, only discussed during the audit.</p>		
<p>Criterion 1.8.3 My complaint shall be addressed and resolved in accordance with the Code of Health and Disability Services Consumers' Rights.</p>	<p>UA High</p>	<p>Whilst there are posters on display in the reception area of the facility on the Code of Health and Disability Services Consumers' Rights (in English, te reo Māori, NZSL, Cantonese, and Mandarin), there is no evidence that the facility manager, staff or volunteer carers were aware of how a complaint should be addressed and resolved in accordance with the Code, and no policy and procedure to outline the steps to be taken if a complaint (of any type) is made. There were no brochures about the Code or the Health and Disability (HDC) Advocacy Service available, and</p>	<p>There is no documentation available to verify that complaints will be managed in accordance with the Code of Health and Disability Services Consumers' Rights. There are no policies and procedures in place to describe to steps to be taken for a complaint, and no brochures available in the facility on the Code, or the HDC Advocacy Service. The facility manager did not understand the complaints/advocacy processes.</p>	<p>Provide evidence that policies and procedures related to complaints management meet the requirements of the Code of Health and Disability Services Consumers' Rights, and that the facility manager has been educated on responsibilities in relation to the complaints process. Provide evidence that information on the Code and the HDC Advocacy service are readily available in the facility.</p> <p>30 days</p>

		the facility manager was unaware of advocacy options for residents.		
<p>Criterion 1.8.4</p> <p>I am informed of the findings of my complaint.</p>	UA High	There was no available evidence to support that complainants are informed of the outcome of their complaint; verbal complaints made by residents around meals have not been documented.	There are no processes in place to ensure residents are formally advised of the outcome of complaints.	<p>Provide evidence that there are processes in place to ensure residents are formally advised of the outcome of complaints.</p> <p>30 days</p>
<p>Criterion 1.8.5</p> <p>The Code of Health and Disability Services Consumers' Rights and the complaints process shall work equitably for Māori.</p>	UA Low	There are no policies and procedures related to the management of complaints at Wesley and no documentation to advise how complaints from Māori (if they were admitted to the service) would be managed to support equity. The facility manager was unaware of the requirement to manage complaints from Māori using culturally safe protocols for Māori (e.g., tikanga related to their hapu or iwi). There were no relationships in place to support Māori if they were in the service to complain. There were no Māori residents in the service.	There were no policies and procedures related to the management of complaints at Wesley and no documentation to advise how complaints from Māori (if they were admitted to the service) would be managed to support equity. The services had no tikanga guidelines to support the complaints process for Māori, or relationships to support Māori in the complaints process if they were to be admitted to the service.	<p>Provide evidence that policies and procedures related to the management of complaints at Wesley document how complaints from Māori (if they were admitted to the service) would be managed to support equity. This includes tikanga guidelines to support the complaints process for Māori, and ensuring appropriate support would be available for them.</p> <p>90 days</p>
<p>Criterion 2.1.1</p> <p>Governance bodies shall ensure compliance with legislative, contractual, and regulatory requirements</p>	UA High	There was no programme to ensure that policies and procedure are in place and implemented at the facility that describe compliance with legislative, contractual, and regulatory	There was no programme to ensure that policies and procedure are in place and implemented at the facility that describe compliance with legislative, contractual and regulatory	Provide evidence that policies and procedures are in place and implemented that are fit for purpose, describe compliance with legislative, contractual, and regulatory requirements, and meet

with demonstrated commitment to international conventions ratified by the New Zealand government.		requirements, including policies and procedures required under the provider's contract with Te Whatu Ora. During the audit, it was advised that Wesley used the same policies as another care home owned by one of the directors, but these policies could not be produced, were not implemented in the service, were last reviewed in 2019, and staff and volunteer carers (with the exception of the clinical manager) did not know about them. A Chinese Culture Policy was in place which was fit for purpose (reviewed 1 September 2024), but staff and volunteer carers interviewed were unaware of its existence.	requirements, including policies and procedures required under the provider's contract with Te Whatu Ora.	the provider's contract with Te Whatu Ora. 60 days
Criterion 2.1.10 Governance bodies shall have demonstrated expertise in Te Tiriti, health equity, and cultural safety as core competencies.	UA Moderate	There was no evidence that either of the directors at Wesley had undergone any training/education in relation to Te Tiriti o Waitangi, health equity, or cultural safety.	The directors cannot demonstrate expertise in health equity, principles and responsibilities in relation to Te Tiriti o Waitangi, or cultural safety.	Ensure the directors complete relevant education and training to develop knowledge and expertise in relation to Te Tiriti o Waitangi, health equity and cultural safety. 90 days
Criterion 2.1.11 There shall be a clinical governance structure in place that is appropriate to the size and complexity of the service provision.	PA Moderate	There is no clinical governance structure in place beyond the employed clinical manager. While information on clinical matters is given to the facility manager by the clinical manager, there is no reporting beyond that (to the other	Wesley has no clinical governance structures in place, clinical risks are not linked to a quality and risk system.	Provide evidence that clinical governance structures have been instituted so that the governance group has oversight of clinical risks as part of a quality and risk systems.

		<p>director or the shareholder who together with the facility manager form the governance group). Governance has no oversight of quality and risk in the organisation, including clinical risks. While information is supplied to the facility manager, there is no record of any discussions between the clinical manager and the governance group to positively enhance clinical services. Clinical management is the sole responsibility of the clinical manager.</p>		90 days
<p>Criterion 2.1.2 Governance bodies shall ensure service providers' structure, purpose, values, scope, direction, performance, and goals are clearly identified, monitored, reviewed, and evaluated at defined intervals.</p>	UA High	<p>There was no documentation or processes in place during the audit to ensure that the service provider's purpose, values, scope, direction, performance and goals are clearly identified, monitored, reviewed and evaluated at defined intervals. An organisational chart was available that showed the structure of the organisation. A document was produced that related to another care home owned by one of the directors of Wesley; however, this had not been reviewed as a Wesley document and was not available in the Wesley electronic or paper systems (a paper copy was produced from the other facility during the audit). There was no evidence that the document</p>	<p>The service's purpose, values, scope, direction, performance and goals are not clearly identified or documented, nor had these been monitored, reviewed or evaluated.</p>	<p>Provide evidence that the service's purpose, values, scope, direction, performance and goals are clearly identified and documented, and that there is a process in place to monitor, review and evaluated these, and the structure of organisation, at defined intervals.</p> <p>60 days</p>

		produced had been reviewed for the Wesley service, that any goals were monitored, nor that there had been any evaluation of the service's structure, purpose, values, scope, direction, performance or goals.		
<p>Criterion 2.1.3</p> <p>Governance bodies shall appoint a suitably qualified or experienced person to manage the service provider with authority, accountability, and responsibility for service provision.</p>	UA High	One of the directors is the facility manager for the service. The facility manager has not managed an aged care service before and was unable to describe the requirements for the role; contractual, legislative or regulatory.	The facility manager needs to develop skills and knowledge related to management of a residential aged care service, including the contractual, legislative and regulatory requirements for the role.	<p>Provide evidence that the facility manager fully understands all the contractual, legislative and regulatory requirements for managing a residential aged care facility.</p> <p>60 days</p>
<p>Criterion 2.1.4</p> <p>Governance bodies shall evidence leadership and commitment to the quality and risk management system.</p>	UA High	There is no effective quality and risk management system in place beyond incident/accident forms (which are not analysed or trended), and a hazard management plan provided as part of the audit (which belongs to another facility owned by one of the directors of the service). There is no overarching quality and risk plan that has been approved by the governing body. The facility manager interviewed was unable to describe the risk matrix usually associated with such plans, despite providing the hazard management plan which used the risk matrix.	There is no overarching quality and risk plan that has been approved by the governing body. The facility manager did not understand the concepts of risk management.	<p>Establish an overarching quality and risk plan that has been approved by the governing body and is relevant for the service provided. Ensure that the facility manager understands the concepts of risk management and how to apply its principles into practice.</p> <p>60 days</p>

<p>Criterion 2.1.5</p> <p>Governance bodies shall ensure service providers deliver services that improve outcomes and achieve equity for Māori.</p>	<p>UA Low</p>	<p>There were no policies in place that related to equity and provision of services for Māori. There were no residents who identified as Māori in the service during the audit.</p>	<p>The service provider is unable to demonstrate how they will improve outcomes and achieve equity for Māori.</p>	<p>Establish methods for ensuring that services improve outcomes and achieve equity for Māori.</p> <p>180 days</p>
<p>Criterion 2.1.8</p> <p>Governance bodies shall support people receiving services and whānau to participate in the planning, implementation, monitoring, and evaluation of service delivery.</p>	<p>PA Moderate</p>	<p>Beyond care planning, there was no evidence that residents were able to participate in the planning, implementation, monitoring and evaluation of service delivery. There was no policy in place to describe how governance would support people receiving services, and whānau, to participate. The facility manager reported that there had been two residents' meetings in 2024, but that no minutes were taken of the meetings. No resident satisfaction surveys have been held.</p>	<p>Evidence of governance commitment to resident and whānau participation could not be demonstrated.</p>	<p>Ensure that people receiving services, and their whanau, are given opportunities to participate in the planning, implementation, monitoring and evaluation of service delivery, and the vehicles to allow this, are written in a policy approved by governance.</p> <p>90 days</p>
<p>Criterion 2.1.9</p> <p>Governance bodies shall have meaningful Māori representation on relevant organisational boards, and these representatives shall have substantive input into organisational operational policies.</p>	<p>UA Moderate</p>	<p>The service does not have any relationships with Māori. This means that there is no meaningful Māori representation into the service and no input by Māori into the organisation's operational policies. Policies and procedures in the facility are minimal. One policy in relation to Māori and Pasifika was produced; the policy</p>	<p>The directors have not yet established links or relationships with local iwi, nor have they determined how they will meet this requirement.</p>	<p>Ensure there is meaningful Māori representation and input into organisational policies and processes.</p> <p>90 days</p>

		was not fit for purpose and had not had input from Māori.		
<p>Criterion 2.2.1</p> <p>Service providers shall ensure the quality and risk management system has executive commitment and demonstrates participation by the workforce and people using the service.</p>	PA High	<p>The organisation does not have a planned quality and risk management system in place. Participation by the workforce is limited to adverse event documentation, and participation from people using the service to care planning.</p>	<p>The organisation does not have a planned quality and risk management system in place that has executive commitment and demonstrates participation by the workforce and people using the service.</p>	<p>Establish a planned quality and risk management system that has executive commitment and demonstrates participation by the workforce and people using the service.</p> <p>60 days</p>
<p>Criterion 2.2.2</p> <p>Service providers shall develop and implement a quality management framework using a risk-based approach to improve service delivery and care.</p>	UA High	<p>The organisation does not have a planned quality and risk management system in place to improve service delivery and care. Information on adverse events and infections is collected by the clinical manager and collated monthly. Monthly numbers are given to the facility manager, but there is no further analysis of adverse events and infections to support quality and risk activities, and there was no evidence of formal reporting to either governance, staff or carers. Resident ethnicity is collected on the forms for adverse events and infections. Information in relation to adverse events and infections is collected, but this is not analysed to support equity or to contribute to quality and risk mitigation processes.</p>	<p>The service provider has not developed and implemented a quality management framework using a risk-based approach to improve service delivery and care.</p>	<p>Provide evidence that a quality management framework has been developed and implemented and that it uses a risk-based approach to improve service delivery and care.</p> <p>60 days</p>

<p>Criterion 2.2.3</p> <p>Service providers shall evaluate progress against quality outcomes.</p>	UA High	<p>There are no processes in place for the service to evaluate progress across quality outcomes. Information on key performance indicators (e.g., falls, skin tears, bruises, pressure injuries, infections, restraint use) is not used to evaluate the service. There are no internal audits, complaints management or feedback systems in place to monitor quality outcomes. There was no evidence of any corrective actions arising from any activity in the service.</p>	<p>There are no processes in place for the service to evaluate progress against quality outcomes and manage a corrective action process.</p>	<p>Establish processes to allow the service to evaluate progress against quality outcomes and manage a corrective action process.</p> <p>60 days</p>
<p>Criterion 2.2.4</p> <p>Service providers shall identify external and internal risks and opportunities, including potential inequities, and develop a plan to respond to them.</p>	UA High	<p>There is no documentation beyond a hazard management plan (which belonged to another facility owned by one of the directors) to identify and mitigate internal and external risks, including inequity. Wesley does not have quality and risk policy framework or a policy portfolio; there is no risk register to include organisational risks. It does not look at its services in relation to equity/inequity.</p>	<p>Wesley does not have a framework or policies in place to identify external and internal risks and opportunities (including potential inequities), nor does it have a plan to respond to them.</p>	<p>Provide evidence that a framework and policies have been established to identify external and internal risks and opportunities (including potential inequities), and the service will respond to and manage them.</p> <p>60 days</p>
<p>Criterion 2.2.5</p> <p>Service providers shall follow the National Adverse Event Reporting Policy for</p>	PA High	<p>There are no processes in place to reduce preventable harm by supporting systems learnings. The only process in place refers to</p>	<p>Not all residents who had an unwitnessed fall or a fall with an observed 'head blow' had neurological observations</p>	<p>Provide evidence that there is a process in place to ensure that all residents who have an unwitnessed fall, or a fall with an</p>

<p>internal and external reporting (where required) to reduce preventable harm by supporting systems learnings.</p>		<p>adverse events and infection data collection, but the process for all adverse events (specifically falls) is not fully completed to ensure resident safety.</p> <p>Adverse event forms were sighted and fully completed by staff. The forms meet the requirements of the National Adverse Events Reporting Policy; however, not all residents who required follow-up following an unwitnessed fall or a witnessed fall with a 'head blow' had neurological observations completed. Neurological observations are taken as standard practice for any unwitnessed falls, or falls where a head blow has been witnessed, to collect information on a resident's neurological status and identify any change that may be detrimental to a resident's wellbeing. There are no policies or procedures to guide staff and carers in relation to best practice.</p> <p>There were five falls in the two months from 17 July 2024-16 September 2024. Two of the falls were unwitnessed; one person had neurological observations fully completed, while the other had two sets of vital sign observations (not neurological observations) completed. Three of the falls were witnessed falls; two had no 'head blow' observed, the other was noted as having had a 'head blow'.</p>	<p>completed. There is no policy or procedure outlining a process for the guidance of staff and carers.</p>	<p>observed 'head blow', have neurological observations completed. The process should be outlined in a policy or procedure document for the guidance of staff and carers.</p> <p>60 days</p>
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		For this person, three sets of vital sign observations had been taken (these were not neurological observations).		
<p>Criterion 2.2.7</p> <p>Service providers shall ensure their health care and support workers can deliver high-quality health care for Māori.</p>	PA Low	There are no fit-for-purpose policies and procedures to guide staff and carers in the care of Māori if they were to enter the service. While there is an education/training programme in place for staff that addressed Te Tiriti of Waitangi and cultural safety, this did not include specific tikanga, te reo Māori, a Māori model of care, or health equity for Māori. There is no access to cultural support for Māori, internally or externally. There were no Māori residents in the service during the audit.	There are no policies, procedures or processes in place to ensure staff and carers can deliver high-quality health care for Māori.	<p>Establish policies, procedures and processes to assist staff and carers to so that they can deliver high-quality health care for Māori, if Māori were to enter the service.</p> <p>180 days</p>
<p>Criterion 2.2.8</p> <p>Service providers shall improve health equity through critical analysis of organisational practices.</p>	PA Moderate	Wesley does not critically analyse organisational practices to improve health equity. While ethnicity information is collected on entry, performance indicators are not analysed using ethnicity data (e.g., adverse events, infections, antimicrobial use, and restraint).	Wesley does not improve health equity through critical analysis of organisational practices.	<p>Provide evidence that a process has been implemented to improve health equity through critical analysis of organisational practices.</p> <p>90 days</p>
<p>Criterion 2.3.1</p> <p>Service providers shall</p>	PA High	Rosters reviewed (four weeks retrospective and two weeks current) showed that staff and	There are insufficient health care and support workers on duty at all times to provide culturally and	Provide evidence that there are sufficient health care and support workers on duty at all times to

<p>ensure there are sufficient health care and support workers on duty at all times to provide culturally and clinically safe services.</p>		<p>volunteer carers are rostered for the facility; however, while staff and volunteer carers are rostered 24 hours per day/seven days per week, there was not always an employed staff member on duty.</p> <p>The CM works 56 hours per fortnight at Wesley, catering to the needs of up to 51 residents (if all beds at Wesley are full) along with responsibility for up to 24 residents at another nearby facility (working as the facility manager/registered nurse according to the clinical manager's contract and position description); a total of up to 75 residents if all rooms are occupied at both Wesley and the other facility (currently reported by the clinical manager as occupancy across both facilities as 63 residents). The CM reported they are rostered to work 32 hours one week and 24 the next at Wesley, with the rest of the time devoted to the other service, up to 40 hours per week. The only support is from another RN who works to cover the CM. It was difficult to ascertain if any actual 'on the ground' work is done by this RN at Wesley on the rosters sighted; they are on the Wesley roster as weekend 'on call'. Added to this, the clinical manager reported needing to work extra hours to make sure all the residents have the clinically and culturally safe services in place</p>	<p>clinically safe services commensurate to the needs and number of residents on site. Not all people who are integral to the roster are employed by the service. There are insufficient clinical manager/registered nurse hours allocated to the facility given the number of residents in the facility and the clinical manager's responsibility for another site.</p>	<p>provide culturally and clinically safe services commensurate to the needs and number of residents on site, and the geography of the facility. Provide evidence that all staff who are integral to the roster are employed by the service. Provide evidence that there are sufficient clinical manager or registered nurse hours allocated to the facility ensure safe services.</p> <p>30 days</p>
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		<p>that were observed during the audit.</p> <p>The facility has 43 residents currently. Apart from the facility manager, the clinical manager, reception, maintenance and gardening, there are 21 staff/volunteer carers who work at the facility; seven designated as kitchen (who may also be doing care work when not working in the kitchen, including giving medication in one instance) and 14 designated as care staff/volunteer carers (who also do kitchen, cleaning, laundry, and activities).</p> <p>From a smaller sample of the rosters available (three weeks), it was evident that morning shifts were covered by a mix of employed staff and volunteer carers, with one or two employed staff members on shift (generally three people on shift). In the afternoon, there were two people rostered for the shift, and on at least five occasions these were voluntary carers; on the night shift there was only one person on duty and on 13 occasions this had been a volunteer carer. Added to this, one staff member/volunteer carer on duty overnight was insufficient for the number of residents and taking into account the geography of the facility. There were staff on the roster (which was a 'rolling</p>		
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		roster') designated as 'E'. On investigation, these people (who could be employed staff or a volunteer carer) were designated as 'extras', but the person who does the roster was unable to say what shift they had actually worked, although reported it was likely to have been either a morning or afternoon shift.		
<p>Criterion 2.3.2</p> <p>Service providers shall ensure their health care and support workers have the skills, attitudes, qualifications, experience, and attributes for the services being delivered.</p>	PA High	Not all people working in the service have had their skills, attitudes, qualifications, experience and attributes for the services being delivered assessed. Volunteer carers have no records available. Applications and/or curriculum vitae were not present in the reviewed files of six employed staff. Reference checks were not produced for employed staff. Some qualifications were present in staff files.	Not all people working to manage the health care and support for residents have had their skills, attitudes, qualifications, experience and attributes for the service assessed. Volunteers are not employed and have no records.	<p>Provide evidence that all people working to manage the health care and support for residents are employed by the service and have had their skills, attitudes, qualifications, experience and attributes for the service assessed.</p> <p>30 days</p>
<p>Criterion 2.3.3</p> <p>Service providers shall implement systems to determine and develop the competencies of health care and support workers to meet the needs of people equitably.</p>	PA Moderate	There are no systems in place to accurately determine the competencies of volunteer carers to meet the needs of people equitably. Volunteer carers are performing caregiving, cleaning, laundry, and kitchen duties. Except in isolated instances (e.g., three volunteer carers who are medication competent), volunteer	There is no implemented system to determine, develop and record the competencies of all people delivering services to residents to meet the needs of people equitably.	<p>Implement systems to determine, develop and record the competencies of staff to meet the needs of residents equitably. Ensure that all staff are regularly provided with opportunities to learn and understand how to meet the needs of people equitably, and that competency records for all people working in the service are</p>

		carers do not have documented competency across fire and emergency systems, moving and handling, health and safety, restraint management, or infection prevention and control.		maintained. 90 days
<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 a plan in place to identify, facilitate and record learning; however, the programme is not well attended and not all the subject matter is available (e.g., care for Pasifika) or complete (e.g., inclusion of te reo Māori and tikanga) to meet the requirements of the Ngā Paerewa Standard and the facility's contract with Te Whatu Ora. In some areas, only small numbers (less than 10) staff/volunteer carers have attended education/training (e.g., restraint and behaviours that challenge) with only education/training on residents' rights (nine staff/volunteer carers), fire and emergency management (22 staff/volunteer carers), medication management (17 staff/volunteer carers), and infection control/outbreak management (23 staff/volunteer carers) well attended. Not all staff/volunteer carers have attended at least eight hours of professional development in the last 11 months.</p>	<p>While there is a plan in place to facilitate and record learning, the programme is not well attended and not all the subject matter is available to support staff/volunteer carers for the benefit of residents. Not all staff/volunteer carers have attended at least eight hours of professional development.</p>	<p>Provide evidence that people working in the service have attended at least eight hours of professional development annually and that the programme being delivered is complete and meets the requirements of Ngā Paerewa and the facility's contract with Te Whatu Ora.</p> <p>90 days</p>

<p>Criterion 2.3.6</p> <p>Service providers shall establish environments that encourage collecting and sharing of high-quality Māori health information.</p>	<p>UA Low</p>	<p>There are no methods yet established, beyond the collection of ethnicity information, for the collection and sharing of high-quality Māori health information. The education programme does not cover the topics of Māori health outcomes and disparities, Māori models of care, and health equity. There were no residents who identified as Māori in the service, and no staff to share their knowledge.</p>	<p>There are no methods yet established for the collection and sharing of high-quality Māori health information. Staff/volunteer carers have had little opportunity to participate in learning opportunities that provide them with the most recent literature on Māori health outcomes and disparities, Māori models of care, and health equity.</p>	<p>Provide records to show that people working in the service have participated in learning opportunities that provide them with the most recent literature on Māori health outcomes and disparities, Māori models of care, and health equity.</p> <p>180 days</p>
<p>Criterion 2.3.7</p> <p>Service providers shall invest in the development of organisational and health care and support worker health equity expertise.</p>	<p>PA Low</p>	<p>Directors have not engaged in education related to health equity. While the education/training programme for staff/volunteer carers includes information on Te Tiriti o Waitangi and cultural competency, this does not include tikanga, te reo Māori, or health equity, and there has been no education in relation to care for Pasifika and tāngata whaikaha. There are no policies and procedures to guide staff/volunteer carers in understanding the concept of health equity. Of the staff interviewed (eight), only one staff member understood the concept. The service is supplying equitable services to the resident population (Chinese, Vietnamese,</p>	<p>Wesley has not invested in the development of health equity expertise for staff/volunteer carers.</p>	<p>Provide evidence that directors and people working in the service have had access to, and have developed an understanding of, health equity.</p> <p>180 days</p>

		and NZ European residents).		
<p>Criterion 2.4.1</p> <p>Service providers shall develop and implement policies and procedures in accordance with good employment practice and meet the requirements of legislation.</p>	UA High	<p>Wesley has no human resources policies and procedures in place to ensure staff are recruited and managed using good employment practice and legislation.</p> <p>There is an employment process in place for staff employed by the service. This includes contracts, position descriptions (though not for infection prevention and control and restraint), police vetting (the director who, along with the HR/shareholder person, relies on Immigration NZ for police vetting as most of the staff/volunteers come from overseas). Information on qualifications was collected in employed staff files. There was no evidence of reference checking, or copies of visas on file (except one staff member who is a resident). Information sighted in employed staff files did not have an application on file (with the exception of one staff member), curriculum vitae, and no references were sighted. Not all staff had contracts that reflected the work they were doing. As an example, in one file sighted for a chef who also worked as a caregiver (and was medication competent), they did not have a contract to cover the dual roles of</p>	<p>There are no policies and procedures implemented in the facility to guide good employment practices. Not all of the staff working in the facility on the roster are employed as required by law using best practice guidelines.</p>	<p>Provide evidence that there are policies and procedures implemented in the facility to guide good employment practices, and that all of the staff working in the facility on the roster are employed as required by the law, using best practice guidelines.</p> <p>30 days</p>

		<p>chef and caregiver.</p> <p>From the information available, of the 21 people involved in care, cleaning, laundry, activities, and food management, only eight were employed by the organisation; the rest were described as volunteers. All of the volunteers were on the roster and had shifts noted. Four volunteers were interviewed, they confirmed that they worked the rostered shifts each week and described being paid a tax-free support payment in lieu of wages. They did know that they were not employed by the service and reported that they were there to get some experience in care and in English language proficiency.</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>	PA High	<p>Not all staff have position descriptions for all the roles they are undertaking. The position description for the clinical manager of Wesley related to the facility manager/registered nurse of another facility owned by one of the directors. The clinical manager did not have a position description related to responsibilities for infection prevention and control and restraint. Most other staff and voluntary carers (with the exception of support staff such as reception, maintenance and gardening) work across different sections of the service; care staff</p>	<p>Wesley does not 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 not documented. Not all staff, and no volunteer carers, have position descriptions relevant to the work they are performing.</p>	<p>Provide evidence that 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. Provide evidence that all people working in the service have position descriptions relevant to the work they are performing.</p> <p>60 days</p>

		(employed or voluntary) may be involved in cleaning, laundry, kitchen and activities work, kitchen staff may be involved in care work. While most of the employed carers have a position description on file, they do not have position descriptions for all their roles; for example, in one file sighted for a chef, they also work as a medication competent caregiver, while they had a position description for their chef role and an assessed medication competency, they did not have a contract on file, or a position description as a caregiver.		
<p>Criterion 2.4.4</p> <p>Health care and support workers shall receive an orientation and induction programme that covers the essential components of the service provided.</p>	<p>PA</p> <p>Moderate</p>	<p>Orientation was documented in six employed staff files reviewed. While the programme does cover most of the essential components of the service, signoff is a 'tick box list' exercise and there is no underlying information in the programme to show what is being learned. The orientation programme includes competency, which are also 'tick boxes', with no supporting documentation to show how the competency had been assessed (with the exception of medication competency).</p> <p>Timeframes for completion are inconsistent; in some instances, the orientation, including competency, is completed in two</p>	<p>There is no evidence to show that people working in the service (staff and volunteer carers) have completed an orientation programme that prepares them for all the roles they are performing in the service.</p>	<p>Provide evidence that an orientation programme is being delivered that prepares people working in the service for any role they are performing in the service.</p> <p>90 days</p>

		<p>to three days (regardless of previous experience), at other times up to six months (without any reason for such an extended time).</p> <p>Volunteers do not have a documented orientation; they have no files of HR information.</p>		
<p>Criterion 2.4.5</p> <p>Health care and support workers shall have the opportunity to discuss and review performance at defined intervals.</p>	<p>PA</p> <p>Moderate</p>	<p>Opportunities to discuss and review performance at defined intervals could not be verified in all files across the seven files sighted. One had a performance appraisal documented, two were not yet due, and three had no performance appraisal on file (including the clinical manager). Volunteer carers have no records to verify whether performance appraisals have been undertaken or not.</p>	<p>Not all people working in the service have the opportunity to discuss and review performance at defined intervals.</p>	<p>Ensure all people working in the service have the opportunity to discuss and review performance at defined intervals.</p> <p>90 days</p>
<p>Criterion 2.5.1</p> <p>Service providers shall maintain quality records that comply with the relevant legislation, health information standards, and professional guidelines, including in terms of privacy.</p>	<p>UA</p> <p>Moderate</p>	<p>Wesley has no policies and procedures in place to describe how it will comply with relevant legislation, health information standards, privacy, or professional guidelines. There was no documented code of conduct or confidentiality agreements beyond minimal responsibilities outlined in employment agreements (volunteer carers did not have employment agreements). Policies</p>	<p>Wesley has no policies and procedures in place to describe how it will comply with relevant legislation, health information standards, privacy, or professional guidelines.</p>	<p>Provide policies and procedures that describe how Wesley will comply with relevant legislation, health information standards, privacy, and professional guidelines.</p> <p>90 days</p>

		and procedures from another facility are being utilised by the clinical manager to inform practice around resident care. The clinical manager is aware of the Nursing Council of New Zealand professional boundary guidelines.		
<p>Criterion 3.1.5</p> <p>Service providers demonstrate routine analysis to show entry and decline rates. This must include specific data for entry and decline rates for Māori.</p>	PA Low	There is no analysis to show entry and decline rates for residents. There is no specific data for entry and decline rates for Māori. No residents who identify as Māori have applied for admission or been declined.	There is no process in place to demonstrate analysis of entry and decline rates for residents, including residents who identify as Māori.	<p>A process to demonstrate collection and analysis of entry and decline rates for residents, including residents who identify as Māori, is to be implemented.</p> <p>180 days</p>
<p>Criterion 3.1.6</p> <p>Prior to a Māori individual and whānau entry, service providers shall:</p> <p>(a) Develop meaningful partnerships with Māori communities and organisations to benefit Māori individuals and whānau;</p> <p>(b) Work with Māori health practitioners, traditional Māori healers, and organisations to benefit Māori individuals and whānau.</p>	PA Low	Wesley has not developed any partnerships with Māori communities and organisations to benefit Māori individuals and whānau, including relationships with Māori health practitioners, traditional Māori healers, and organisations to benefit Māori individuals and whānau. There were no residents who identified as Māori in the service during the audit.	No meaningful partnerships with Māori communities and organisations to benefit Māori individuals and whānau have been developed, these include relationships with Māori health practitioners, traditional Māori healers, and organisations to benefit Māori individuals and whānau.	<p>Develop meaningful partnerships with Māori communities and organisations to benefit Māori individuals, including relationships with Māori health practitioners, traditional Māori healers, and organisations to benefit Māori individuals and whānau.</p> <p>180 days</p>

<p>Criterion 3.5.4</p> <p>The nutritional value of menus shall be reviewed by appropriately qualified personnel such as dietitians.</p>	<p>UA Moderate</p>	<p>There were no policies or procedures in place around food services (refer criterion 2.1.1). The menu in place has not been reviewed by an appropriately qualified person, such as a dietitian. Some of the residents and whānau interviewed noted that they did not like the food, while others were more positive. No formal complaints about food have been made (refer criterion 1.8.2). There are no approved recipes available for use for food services.</p>	<p>The nutritional value of menus has not been reviewed by an appropriately qualified person, such as a dietitian. There are no approved recipes for use for food preparation.</p>	<p>Provide evidence that the nutritional value of menus has been reviewed by an appropriately qualified person, such as a dietitian, and that there are approved recipes available to be followed for food preparation.</p> <p>180 days</p>
<p>Criterion 3.5.7</p> <p>Service providers adopt a holistic approach to menu development that ensures nutritional value, respecting and supporting cultural beliefs, values, and protocols around food. Māori and whānau shall have menu options culturally specific to te ao Māori.</p>	<p>PA Low</p>	<p>The service has adopted a holistic approach to menu development that respects and supports cultural beliefs, values, and protocols around food. There are no menu options culturally specific to te ao Māori. There were no Māori resident in the service during the audit.</p>	<p>The service has no menu options culturally specific to te ao Māori.</p>	<p>Institute menu options culturally specific to te ao Māori.</p> <p>180 days</p>
<p>Criterion 4.2.3</p> <p>Health care and support workers shall receive appropriate information, training, and equipment to respond to identified</p>	<p>PA Moderate</p>	<p>Fire extinguishers were available in the facility (three sighted); it was reported that two were new and had not required checking but there was no evidence of this (neither had been tagged), while one was older and had last been</p>	<p>There were no processes in place to record safety checking of fire extinguishers.</p>	<p>Provide evidence that there is a process in place to check fire extinguishers annually.</p> <p>30 days</p>

emergency and security situations. This shall include fire safety and emergency procedures.		checked in 2019.		
<p>Criterion 5.1.1</p> <p>The governance body shall identify the IP and AMS programmes as integral to service providers' strategic plans (or equivalent) to improve quality and ensure the safety of people receiving services and health care and support workers.</p>	PA Moderate	There are no strategic plans in place, therefore infection prevention (IP) and antimicrobial stewardship (AMS) programmes are not integral to any strategic planning. Wesley has no policies and procedures to guide staff in the management of infections and antibiotic use. While the clinical manager has access to policies and procedures related to infection prevention and control and antimicrobial use via another care facility (refer criterion 2.1.1), these have not been reviewed since 2019.	Infection prevention and AMS programmes have not been identified as integral to the services being provided at Wesley. There are no strategic plans (or equivalent) which would allow such documentation.	<p>Ensure IP and AMS are identified as integral to strategic plans (or equivalent) when these are put into place.</p> <p>90 days</p>
<p>Criterion 5.1.2</p> <p>There shall be a formally agreed mechanism for accessing appropriate IP and AMS expertise that assists with defining the strategic direction and provides advice to the governance body.</p>	PA Moderate	Wesley can source appropriate IP and AMS expertise from clinical specialists at Te Whatu Ora and regional public health on an 'as needed' basis. There is no vehicle (e.g., aggregated information trended over time) for this information to be used strategically.	There is no formally agreed mechanism for accessing appropriate IP and AMS expertise that assists with defining the strategic direction of the organisation.	<p>Institute a formally agreed mechanism for accessing appropriate IP and AMS expertise that assists with defining the strategic direction of the organisation. Put a strategic plan (or equivalent) in place that includes IP and AMS.</p> <p>90 days</p>
<p>Criterion 5.2.13</p> <p>IP personnel and</p>	PA Low	Wesley has no partnerships with Māori for the protection of culturally safe practice in IP, to	There are no partnerships with Māori for the protection of culturally safe practice in IP, to	Institute partnerships with Māori for the protection of culturally safe practice in IP, to acknowledge the

committees shall participate in partnership with Māori for the protection of culturally safe practice in IP, and thus acknowledge the spirit of Te Tiriti.		acknowledge the spirit of Te Tiriti o Waitangi.	acknowledge the spirit of Te Tiriti o Waitangi.	spirit of Te Tiriti o Waitangi. 180 days
<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; and</p> <p>(d) Reviewed and reported on annually.</p>	PA Moderate	The IP programme in use at Wesley belongs to another facility and is not specific to the Wesley service. It has not been approved by the governing body, is not linked to the quality and risk programme, and is not reviewed and reported on annually.	There is no IP programme in place specific to Wesley. The programme in place has not been approved by the governing body, is not linked to a quality and risk programme, and is not reviewed and reported on annually.	<p>Ensure the IP programme in place at Wesley is specific to Wesley, that the programme has been approved by the governing body and linked to a quality and risk programme, and that the programme is reviewed and reported on annually.</p> <p>90 days</p>
<p>Criterion 5.2.3</p> <p>Service providers shall develop written IP policies with input from suitably qualified personnel, which comply with relevant legislation and accepted best practice. The suite of policies shall include:</p> <p>(a) Hand hygiene and standard precautions;</p> <p>(b) Aseptic technique;</p> <p>(c) Transmission-based precautions;</p>	PA Moderate	The IP programme in use at Wesley belongs to another facility and is not specific to the Wesley service. No policies were supplied that met the provider's requirement to meet the Ngā Paerewa Standard or the provider's agreement with Te Whatu Ora.	The service provider has not developed written IP policies with input from suitably qualified personnel, which comply with relevant legislation and accepted best practice.	<p>Provide evidence that the service provider has developed written IP policies with input from suitably qualified personnel, which comply with relevant legislation and accepted best practice.</p> <p>90 days</p>

<p>(d) Prevention of sharps injuries; (e) Prevention and management of communicable infectious diseases in service providers and users; (f) Management of current and emerging multi-drug-resistant organisms; (g) Outbreak management; (h) Decontamination and reprocessing of reusable medical devices and equipment; (i) Single-use items; (j) Health care-associated infection (HAI) surveillance; (k) The built environment.</p>				
<p>Criterion 5.3.1 Service providers shall have a documented AMS programme that sets out to optimise antimicrobial use and minimising harm. This shall be: (a) Appropriate for the size, scope, and complexity of the service; (b) Approved by the governance body; (c) Developed using evidence-based antimicrobial prescribing guidance and expertise (which includes restrictions</p>	<p>PA Moderate</p>	<p>The current AMS programme is personalised to another facility and has not been approved by the Wesley governance group.</p>	<p>Wesley does not have a documented AMS programme in place that sets out to optimise antimicrobial use, minimise harm, that is relevant to the service and has been approved by the governance group.</p>	<p>Provide evidence that Wesley has a documented AMS programme in place that sets out to optimise antimicrobial use, minimise harm and that is relevant to the service. Provide evidence that the AMS programme has been approved by the governance group.</p> <p>90 days</p>

and approval processes where necessary and access to laboratory diagnostic testing reports).				
<p>Criterion 5.3.2</p> <p>Service providers shall have policies and guidelines in place, appropriate to the size, scope, and complexity of the service, which will comply with evidence-informed practice.</p>	PA Moderate	Wesley does not have documented policies and procedures in place in relation to AMS management. The AMS programme in place is personalised to another facility owned by one of the Wesley directors and managed part-time by the Wesley clinical manager.	Wesley does not have documented policies and procedures in place in relation to AMS management and which will comply with evidence-informed practice.	<p>Provide evidence that Wesley has documented policies and procedures in place in relation to AMS management which comply with evidence-informed practice.</p> <p>90 days</p>
<p>Criterion 5.4.4</p> <p>Results of surveillance and recommendations to improve performance where necessary shall be identified, documented, and reported back to the governance body and shared with relevant people in a timely manner.</p>	PA Moderate	Results of surveillance and recommendations to improve performance have not been identified. Monthly surveillance data has not been collated or analysed to identify any trends, possible causative factors or required actions to mitigate these. There is no evidence that the results of surveillance activities are reported to staff/volunteer carers. The facility manager, who is part of the governance group, has access to surveillance data collected by the clinical manager.	The processes for analysing the results of surveillance of HAIs is not in place. Information collected is not collated to identify any trends, possible causative factors or required actions to mitigate these. Results are not reported to staff/volunteer carers.	<p>Provide evidence that processes for analysing the results of surveillance of HAIs is in place, that the information is collated to identify any trends, possible causative factors and required actions to mitigate these. Provide evidence that the results of surveillance activities are reported to staff/volunteer carers.</p> <p>90 days</p>
<p>Criterion 5.5.1</p> <p>Service providers shall</p>	PA Moderate	There are no policies and procedures in place to guide staff on the appropriate storage and	There are no policies and procedures in place to guide staff on the appropriate storage and	Provide evidence that policies and procedures are in place to guide staff on the appropriate storage

<p>ensure safe and appropriate storage and disposal of waste and infectious or hazardous substances that complies with current legislation and local authority requirements. This shall be reflected in a written policy.</p>		<p>disposal of waste and infectious or hazardous substances as it applied to the law and local authority requirements beyond material data safety sheets (MDSS - held in the cleaning and laundry areas to guide staff in actions to take if a spillage occurred). During the audit, staff/volunteer carers were noted to be managing waste and hazardous substances following good practice and there was a hazard management plan in place relating to risk. While there were no infections in the facility requiring any special care, staff/volunteer carers interviewed were able to describe the processes in place to manage infectious waste and there was equipment available in the facility for them to manage these safely.</p>	<p>disposal of waste and infectious or hazardous substances as it applied to the law and local authority requirements.</p>	<p>and disposal of waste and infectious or hazardous substances as it applied to the law and local authority requirements.</p> <p>90 days</p>
<p>Criterion 5.5.4 Service providers shall ensure there are safe and effective laundry services appropriate to the size and scope of the health and disability service that include: (a) Methods, frequency, and materials used for laundry processes; (b) Laundry processes being monitored for effectiveness;</p>	<p>PA Moderate</p>	<p>There are no written policies in place to guide safe and effective laundry services, and no clear separation of clean and dirty areas in the laundry area and no demarcation to indicate to staff/volunteer carers as to which was the clean side of the laundry, and which was the dirty side. There are two doors into the laundry area; however, there are no entry/exit signs on the doors to guide staff on which door to enter and exit by. Staff/volunteer carers</p>	<p>Laundry services are unsafe, there is no clear separation and demarcation of clean/dirty laundry areas, there is no signage to indicate an entry and exit door. The space is not secured for the safe storage of chemicals.</p>	<p>Institute written policies to guide safe laundry services. Ensure that there is a clear separation and demarcation of clean and dirty areas in the laundry area, and that entry/exit doors are appropriately labelled. Ensure access into the laundry is secure and allows for the safe storage of laundry chemicals.</p> <p>90 days</p>

(c) A clear separation between handling and storage of clean and dirty laundry; (d) Access to designated areas for the safe and hygienic storage of laundry equipment and chemicals. This shall be reflected in a written policy.		were observed using either door to enter into the laundry area. Access into the laundry is not secure and does not allow for the safe storage of laundry chemicals.		
Criterion 5.5.5 Service providers shall ensure that the IP role has – or IP personnel have – oversight of the facility testing and monitoring programme for the built environment.	PA Low	The IPCC role has no job description to ensure they understand their responsibilities to facility testing and monitoring of the built environment. There is no internal auditing of the built environment (refer criterion2.2.4).	There is no documentation to guide the IPCC in their responsibilities, including the responsibility for facility testing and monitoring of the built environment.	Ensure the IPCC has a current job description that describes their responsibilities for facility testing and monitoring the built environment. 180 days
Criterion 6.1.1 Governance bodies shall demonstrate commitment toward eliminating restraint.	PA Moderate	There is no documentation to support the facility working to eliminate restraint; there are no policies and procedures or any other strategic documents at Wesley that lay out the intentions of the governance group.	The governance group is unable to demonstrate commitment toward eliminating restraint.	Provide evidence that the governance group has a commitment to eliminate restraint through the provision of a restraint elimination programme, policy and procedure to guide the programme, and a commitment in strategic (or equivalent) documentation. 90 days
Criterion 6.1.4 Executive leaders shall report restraint used at	PA Moderate	The clinical manager understood the processes related to restraint and has access to policies from	Restraint is reported at defined intervals, but restraint data, including the type and frequency	Provide evidence that restraint data, including the type and frequency of restraint, is

<p>defined intervals and aggregated restraint data, including the type and frequency of restraint, to governance bodies. Data analysis shall support the implementation of an agreed strategy to ensure the health and safety of people and health care and support workers.</p>		<p>another (nearby) facility to guide practice. The clinical manager reports restraint uses on a monthly basis to the facility manager; however, aggregated data in relation to restraint is not kept, restraint is not trended over time, and there is no policy in place that lays out an agreed strategy to ensure the health and safety of residents who are using restraint or staff/volunteer carers. The directors of the service, one of whom is the facility manager, were aware of the restraint use.</p>	<p>of restraint, is not aggregated or trended over time. Data analysis does not support the elimination of restraint, or the implementation of an agreed strategy to ensure the health and safety of residents who are using restraint or staff/volunteer carers.</p>	<p>aggregated and trended over time. Data analysis is to be used to support the implementation of an agreed strategy to eliminate restraint, and where this is not possible, to ensure the health and safety of residents who are using restraint and staff/volunteer carers.</p> <p>90 days</p>
<p>Criterion 6.1.5 Service providers shall implement policies and procedures underpinned by best practice that shall include: (a) The process of holistic assessment of the person's care or support plan. The policy or procedure shall inform the delivery of services to avoid the use of restraint; (b) The process of approval and review of de-escalation methods, the types of restraint used, and the duration of restraint used by the service provider; (c) Restraint elimination and use of alternative</p>	<p>PA Moderate</p>	<p>Restraint is documented in the care plans of residents using restraint; however, while the clinical manager has access to restraint policy from another facility, Wesley does not have policy and procedure of its own to guide practice.</p>	<p>There are no policies and procedures to guide restraint use at Wesley.</p>	<p>Policy and procedure, underpinned by best practice, is to be sourced and implemented at Wesley to guide practice.</p> <p>90 days</p>

<p>interventions shall be incorporated into relevant policies, including those on procurement processes, clinical trials, and use of equipment.</p>				
<p>Criterion 6.3.1</p> <p>Service providers shall conduct comprehensive reviews at least six-monthly of all restraint practices used by the service, including:</p> <ul style="list-style-type: none"> (a) That a human rights-based approach underpins the review process; (b) The extent of restraint, the types of restraint being used, and any trends; (c) Mitigating and managing the risk to people and health care and support workers; (d) Progress towards eliminating restraint and development of alternatives to using restraint; (e) Adverse outcomes; (f) Compliance with policies and procedures, and whether changes are required; (g) Whether the approved restraint is necessary; safe; of an appropriate duration; and in accordance with the person's and health care 	<p>PA Low</p>	<p>Six-monthly review of restraint only just became due in September 2024. The clinical manager is aware that the review is to be undertaken and has documentation available ready to proceed.</p>	<p>Six-monthly review of restraint cannot be verified as it has only just become due.</p>	<p>Ensure six-monthly review of restraint is undertaken in September 2024.</p> <p>90 days</p>

<p>and support workers' feedback and current evidenced-based best practice;</p> <p>(h) If the person's care or support plans identified alternative techniques to restraint;</p> <p>(i) The person and whānau, perspectives are documented as part of the comprehensive review;</p> <p>(j) Consideration of the role of whānau at the onset and evaluation of restraint;</p> <p>(k) Data collection and analysis (including identifying changes to care or support plans and documenting and analysing learnings from each event);</p> <p>(l) Service provider initiatives and approaches support a restraint-free environment;</p> <p>(m) The outcome of the review is reported to the governance body.</p>				
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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, there is a message “no data to display” then no continuous improvements were recorded as part of this audit.

No data to display

End of the report.