Kaylex Care (Waipukurau) Limited - Mt Herbert House

Introduction

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

The audit has been conducted by 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:	Kaylex Care (Waipukurau) Limited
Premises audited:	Mt Herbert House
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 13 January 2025 End date: 14 January 2025

Proposed changes to current services (if any): The provider intended to build a 10-bed extension onto the existing facility, but this did not occur due to the difficulty in accessing general practitioner services. The service is now working to create a secure dementia care village for up to 20 residents.

Total beds occupied across all premises included in the audit on the first day of the audit: 33

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Mt Herbert House is certified to provide rest home and hospital level care for up to 42 residents. The facility is owned by Kaylex Care (Waipukurau) Limited and is managed by a facility manager.

This certification audit process was conducted against Ngā Paerewa Health and Disability Services Standard NZS 8134:2021 and the contracts the service holds with Te Whatu Ora – Health New Zealand. It included review of policies and procedures, review of residents' and staff files, observations, and interviews with residents and whānau, a governance representative, staff, and a general practitioner. Residents and whānau were complimentary about the care provided.

Up until 2024, the service planned to build a 10-bed extension onto the existing facility, but this did not occur due to the difficulty in accessing general practitioner services. The service is now working to create a secure dementia care village for up to 20 residents. The concept is being supported by Te Whatu Ora and work in the area has commenced.

Improvements identified during the audit related to the quality system, registered nurse cover, communication, general practitioner cover, care planning, medication management and restraint.

Ō tātou motika | Our rights

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

Mt Herbert House has Māori and Pasifika health policies in place. The policies define the service's commitment to equity for Māori and Pasifika and outline appropriate models of care reflecting cultural considerations. Staff were observed to engage with residents in a culturally safe way during the audit. The service provider is aware of the requirement to recruit and retain Māori and Pasifika in its workforce and this is reflected in policy documentation. There were Māori and Pasifika staff employed in the service during the audit.

Mt Herbert House collaborated with staff to support residents. All staff had received in-service education on the Code of Health and Disability Services Consumers' Rights (the Code). The service was socially inclusive and person-centred. Personal identity, independence, privacy and dignity were respected and supported. Residents who identified as Māori were treated equitably and confirmed that their mana motuhake (self-determination) was maintained. Te reo Māori and tikanga Māori were incorporated in daily practices. There was no evidence of abuse, neglect or discrimination, and the service promotes an environment that addresses systemic and institutional racism.

Pacific peoples are provided with services that recognise their worldviews; residents who identified as Pasifika confirmed that services delivered are culturally safe. Mt Herbert House responded to tāngata whaikaha (people with disability) needs enabling their participation in te ao Māori.

Where information is provided, residents and whānau confirmed that they received information in an easy-to-understand format. Interpreter services were provided as needed. Whānau and legal representatives participate in decision-making that complies with the law. Advance directives are followed wherever possible.

Complaints were resolved promptly and effectively in collaboration with all parties involved. There were processes in place to ensure that the complaints process works equitably for Māori.

Hunga mahi me te hanganga | Workforce and structure

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

Kaylex Care (Waipukurau) Limited, as the governing body, is committed to delivering quality services at Mt Herbert House, honouring Te Tiriti o Waitangi and reducing barriers to improve outcomes for Māori, Pasifika and tāngata whaikaha. Directors (two) are suitably experienced in governance and one of the directors has completed education in cultural awareness, Te Tiriti o Waitangi and health equity.

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

There is a quality and risk management system in place that focuses on improving service delivery and care. The system requires the collection and analysis of quality improvement data to identify trends, leading to improvements. Adverse events and infections are documented. The service complies with statutory and regulatory reporting obligations.

Staff are appointed, orientated and managed using current good practice. Staff are suitably skilled and experienced. Staffing levels were sufficient to provide clinically and culturally appropriate care. A systematic approach to identify and deliver ongoing learning supports safe equitable service delivery.

Residents' information was accurately recorded and securely stored, and was not on public display or 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 are partially attained and of medium or high risk and/or unattained and of low risk.

When people enter the service, a person-centred and whānau-centred approach is adopted. Relevant information is provided pre-admission to the potential resident and their whānau.

The service works in partnership with the residents to assess and evaluate care. Files reviewed demonstrated that care 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 age and stage of life.

Medicines were administered by staff who have been assessed as competent to do so.

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

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

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

Includes 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.		Subsections applicable to this service are fully attained.

The facility meets the needs of residents and was clean and well-maintained. There is a current building warrant of fitness. Electrical and biomedical equipment have been checked and assessed as required. Internal and external areas are accessible and safe, and external areas have shade and seating provided and meet the needs of tāngata whaikaha.

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

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

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

Mt Herbert House ensured the safety of residents and staff through a planned infection prevention (IP) and antimicrobial stewardship (AMS) programme that was appropriate to the size and complexity of the service. An experienced and trained infection coordinator leads the programme.

The infection coordinator participates 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 managed. There were safe and effective laundry services.

Here taratahi | Restraint and seclusion

Includes four subsections that support outcomes where Services shall aim for a restraint and seclusion free environment, in which people's dignity and mana are maintained.		Some subsections applicable to this service are partially attained and of medium or high risk and/or unattained and of low risk.

The service aims for a restraint-free environment, and this is supported by the service's policies and procedures. There were four residents using restraint at the time of audit. A suitably qualified restraint coordinator, who is a registered nurse, manages the

process. Staff interviewed demonstrated a sound knowledge and understanding of providing least restrictive practice, de-escalation techniques, and alternative interventions to restraint.

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	22	0	1	6	0	0
Criteria	0	165	0	2	9	0	0

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

Attainment against the Ngā paerewa Health and disability services standard

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

For more information on the standard, please click here.

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

Subsection with desired outcome	Attainment Rating	Audit Evidence
Subsection 1.1: Pae ora healthy futures Te Tiriti: Māori flourish and thrive in an environment that enables good health and wellbeing. As service providers: We work collaboratively to embrace, support, and encourage a Māori worldview of health and provide high-quality, equitable, and effective services for Māori framed by Te Tiriti o Waitangi.	FA	Mt Herbert House (Mt Herbert) has policies, procedures and processes to embed and enact Te Tiriti o Waitangi in all aspects of its work. Partnerships have been established with a kaitakawaenga (Māori cultural adviser) from the local Te Whatu Ora Māori Support Unit to support service integration, planning, equity approaches and support (including rongoā support) for Māori. The service also engages with Terrace School (a local bilingual school) for the benefit of the school and the Māori residents in the service. A Māori health plan has been developed with input from cultural advisors and is used for residents who identify as Māori. There were Māori residents present in the facility during the audit, and one of the residents acts as a kaumatua for the service. Māori residents and their whānau participate in providing input into their care planning, activities, and dietary needs. Care plans included the physical, spiritual, whānau, and psychological health of the residents. Māori residents and their whānau interviewed reported that they were comfortable at the facility and expressed feelings and experiences that are consistent with cultural safety, confirming that mana motuhake (self-determination) is respected. Strategies to actively recruit and retain a Māori health workforce

		across roles were discussed. At the time of audit, there were staff employed who identified as Māori. Staff ethnicity data is documented on recruitment and trended.
Subsection 1.2: Ola manuia of Pacific peoples in Aotearoa The people: Pacific peoples in Aotearoa are entitled to live and enjoy good health and wellbeing. Te Tiriti: Pacific peoples acknowledge the mana whenua of Aotearoa as tuakana and commit to supporting them to achieve tino rangatiratanga. As service providers: We provide comprehensive and equitable health and disability services underpinned by Pacific worldviews and developed in collaboration with Pacific peoples for improved health outcomes.	FA	The service provider has a health plan in place that describes how the service will respond to the cultural needs of Pasifika residents. The document notes Pasifika worldviews, the need to embrace cultural and spiritual beliefs, and outlines the Fonofale model of care specific to residents from Pacific nations, and on achieving equity. A partnership with a Pasifika spiritual organisation enables support for Pasifika residents and ongoing planning and evaluation of services and outcomes. Pasifika residents and their whānau interviewed felt their worldview, and cultural and spiritual beliefs, were embraced. Active recruitment, training and actions to retain a Pacific workforce are supported through policy, resulting in Pasifika staff being employed in the service.
Subsection 1.3: My rights during service delivery The People: My rights have meaningful effect through the actions and behaviours of others. Te Tiriti:Service providers recognise Māori mana motuhake (self-determination). As service providers: We provide services and support to people in a way that upholds their rights and complies with legal requirements.	FA	Staff interviewed at Mt Herbert 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. Evidence was sighted of staff having received recent training on the Code, abuse and neglect, informed consent and privacy by the Nationwide Health and Disability Advocacy Service (Advocacy Service). Residents and whānau interviewed reported that they were made aware of the Code and the Advocacy Service and were provided with opportunities to discuss and clarify their rights. Posters on the Code were on display around the facility, with brochures on the Code and the Advocacy Service available at the front entrance. This information was also available in the information pack supplied on admission.

Subsection 1.4: I am treated with respect The People: I can be who I am when I am treated with dignity and respect. Te Tiriti: Service providers commit to Māori mana motuhake. As service providers: We provide services and support to people in a way that is inclusive and respects their identity and their experiences.	FA	Mt Herbert supported residents in a way that was inclusive and respected their identity and experiences. Residents and whānau, including people with disabilities, confirmed that they received services in a manner that had regard for their dignity, gender, privacy, sexual orientation, spirituality and choices. Staff were observed to maintain privacy throughout the audit. All residents had a private room. Residents verified opportunities are provided to share what is important to them, and this is taken into consideration in care planning. Te reo Māori and tikanga Māori are promoted within the service. Māori residents in the service are supported through a kaumatua (who is a resident in the service), and a kaitakawaenga (Māori cultural adviser) from the local Te Whatu Ora. Staff have undertaken training in Te Tiriti o Waitangi and understood the principles and how to apply these in their daily work. The needs of tāngata whaikaha are responded to, including their participation in te ao Māori.
Subsection 1.5: I am protected from abuse The People: I feel safe and protected from abuse. Te Tiriti: Service providers provide culturally and clinically safe services for Māori, so they feel safe and are protected from abuse. As service providers: We ensure the people using our services are safe and protected from abuse.	FA	Staff understood the service's policy on abuse and neglect, including what to do should there be any signs of such. There were no examples of discrimination, coercion or harassment identified during the audit through staff and/or resident and whānau interviews, or in documentation reviewed. Residents and their whānau reported that their property is respected and their finances protected. Staff maintain professional boundaries. Staff interviewed felt comfortable raising any concerns in relation to institutional and systemic racism and that any concerns would be acted upon. A strengths-based and holistic model of care was evident. Care plans were individualised and included use of Te Whare Tapa Whā and Fonofale models of care for residents who identified as Māori and Pasifika.

Subsection 1.6: Effective communication occurs The people: I feel listened to and that what I say is valued, and I feel that all information exchanged contributes to enhancing my wellbeing. Te Tiriti: Services are easy to access and navigate and give clear and relevant health messages to Māori. As service providers: We listen and respect the voices of the people who use our services and effectively communicate with them about their choices.	PA Moderate	When information was provided to residents of Mt Herbert and their whānau, it was in an easy-to-understand format. Residents reported that communication was open and effective, and they felt listened to; however, for several whānau interviewed this was not the case. Changes to residents' health status, and the occurrence of incidents, were often not communicated to whānau in a timely manner. Staff members working at Mt Herbert were not wearing name badges to ensure residents and whānau were able to identify staff to whom they were talking. These are areas that need to be addressed (refer criterion 1.6.3). Where other agencies participated in care, communication had occurred. Staff knew how to access interpreter services, if required.
Subsection 1.7: I am informed and able to make choices The people: I know I will be asked for my views. My choices will be respected when making decisions about my wellbeing. If my choices cannot be upheld, I will be provided with information that supports me to understand why. Te Tiriti: High-quality services are provided that are easy to access and navigate. Providers give clear and relevant messages so that individuals and whānau can effectively manage their own health, keep well, and live well. As service providers: We provide people using our services or their legal representatives with the information necessary to make informed decisions in accordance with their rights and their ability to exercise independence, choice, and control.	FA	Residents and/or their legal representative are provided with the information necessary to make informed decisions. They felt empowered to actively participate in decision-making. With the consent of the resident, whānau were included in decision-making. Nursing and care staff interviewed understood the principles and practice of informed consent, supported by policies in accordance with the Code and in line with tikanga guidelines. Advance care planning, establishing, and documenting Enduring Power of Attorney (EPOA) requirements and processes for residents unable to consent were documented, as relevant, in the resident's record.
Subsection 1.8: I have the right to complain The people: I feel it is easy to make a complaint. When I complain I am taken seriously and receive a timely response. Te Tiriti: Māori and whānau are at the centre of the health and disability system, as active partners in improving the system and	FA	A fair, transparent and equitable system was in place to receive and resolve complaints that leads to improvements. This met the requirements of consumer rights legislation. All residents and their whānau are provided with information on entry regarding the complaints process and advocacy services, and complaints

their care and support. As service providers: We have a fair, transparent, and equitable system in place to easily receive and resolve or escalate complaints in a manner that leads to quality improvement.		information is available in te reo Māori. Information regarding the complaints process is displayed in the facility, along with advocacy information. Residents and whānau interviewed understood their right to make a complaint and knew how to do so. There have been two complaints received in the last 12 months. Documentation sighted in respect of the complaints showed that they had been responded to within appropriate timeframes and that the complainants had been informed of findings following investigation. There have been no complaints received from external sources since the previous audit. The FM, who manages complaints, was able to describe the processes the service has in place in policy to ensure complaints from Māori would be treated in a culturally appropriate and equitable fashion. This included the use of an interpreter (if required) and engagement with the resident and their whānau in a way culturally appropriate for them (e.g., with the use of hui and iwi appropriate tikanga).
Subsection 2.1: Governance The people: I trust the people governing the service to have the knowledge, integrity, and ability to empower the communities they serve. Te Tiriti: Honouring Te Tiriti, Māori participate in governance in partnership, experiencing meaningful inclusion on all governance bodies and having substantive input into organisational operational policies. As service providers: Our governance body is accountable for delivering a highquality service that is responsive, inclusive, and sensitive to the cultural diversity of communities we serve.	FA	The Kaylex Care (Waipukurau) Limited (Kaylex Care) directors assume accountability for delivering a high-quality service through culturally appropriate policy and procedures. The directors (two) of Kaylex Care and the facility manager (FM) of Mt Herbert honour Te Tiriti o Waitangi, and are focused on improving outcomes for all residents, including those who are Māori, Pasifika, or tāngata whaikaha. Governance has access to a Kaitakiwaenga from the local Te Whatu Ora cultural support unit for organisational support at governance level. One of the directors of Kaylex Care has completed education on Te Tiriti o Waitangi, health equity, and cultural safety to support equitable oversight of the delivery of care. The leadership and clinical structure at Mt Herbert is appropriate to the size and complexity of the organisation and there is an experienced and suitably qualified person (the FM) managing the service. The FM, who is a registered nurse (RN), confirmed knowledge of the sector, including regulatory and reporting requirements.

		The purpose, values, direction, scope and goals are defined, and monitoring and reviewing of performance occurs through regular reporting at planned intervals. A focus on identifying barriers to access, improving outcomes, and achieving equity for Māori, Pasifika and tāngata whaikaha was evident in plans and monitoring documentation reviewed. Ethnicity data is being collected to support equity. Equity is also supported through choice and control over supports and the removal of barriers that prevent access to information (e.g., information in other languages for the Code, complaints, infection prevention and control, and bilingual signage). Mt Herbert promotes appropriate models of care specific to residents' cultural needs, including for Māori and Pasifika. There is a Māori health plan in place that guides care for Māori, and a plan to guide care for Pacific people and these have had appropriate cultural input. There was no evidence of infrastructural, financial, physical, or other barriers to equitable service delivery. This was supported by interviews with residents and their whānau, managers, and with staff. Governance and the senior leadership team are committed to quality and risk via policy, processes, and through feedback mechanisms. Most internal quality data is aggregated (adverse events, complaints, infections, and antimicrobial use) with corrective actions completed where deficits are identified; the exception to this is in internal auditing (refer criterion 2.2.3) and restraint (refer subsection 6.2). A sample of facility reports and graphs showed adequate information on adverse events, complaints, infections, and antimicrobial use is reported to monitor performance. The director interviewed reported that they felt well informed on progress and risks. Residents and staff contribute to quality improvement through the ability to give feedback at meetings and in surveys. Residents hold meetings, and there was evidence of discussion of matters raised from residents in meeting minutes sighted. A resident satisfaction survey completed in 2024 (with 21 responses) showed satisfaction with the services provided. Residents and whānau interviewed also reported satisfaction with services when interviewed. The service holds contracts with Te Whatu Ora for aged-related rest

		home and hospital care services, long term support-chronic health conditions (LTS-CHC), and short-term care (respite). The service also holds a contract with the Accident Compensation Corporation (ACC) to provide support services. On the day of audit, 33 residents were receiving services: 15 receiving rest home services (including one on an LTS-CHC contract, one on respite and two on ACC contracts) and 18 hospital level services (including three on LTS-CHC contracts and one on an ACC contract).
Subsection 2.2: Quality and risk The people: I trust there are systems in place that keep me safe, are responsive, and are focused on improving my experience and outcomes of care. Te Tiriti: Service providers allocate appropriate resources to specifically address continuous quality improvement with a focus on achieving Māori health equity. As service providers: We have effective and organisation-wide governance systems in place relating to continuous quality improvement that take a risk-based approach, and these systems meet the needs of people using the services and our health care and support workers.	PA Moderate	Policies and procedures reviewed covered all necessary aspects of the service and of contractual requirements and were current. Policies and procedures are outsourced to an external provider; these are used as templates for the facility and edited to reflect the services being provided at Mt Herbert. Policies and procedures related to the care of Māori and Pasifika have had input from Māori and Pasifika. The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. The FM described the processes Mt Herbert uses for the identification, documentation, monitoring, review and reporting of risks (including clinical and health and safety risks), and development of mitigation strategies. This includes management of adverse events (including the monitoring of hazards and clinical incidents, for example, falls, pressure injuries, infections, wounds, and medication errors), audit activities, compliments and complaints, resident and whānau feedback from meetings and the satisfaction survey, and policies and procedures. Most of the quality system is well done and accurately recorded and reported. The exception is in the areas of internal auditing and adverse event follow-up and communication (refer criteria 1.6.3 and 2.2.3). Staff documented adverse and near miss events in line with the National Adverse Events Reporting Policy in relation to information collection and data analysis and review. Incidents and accidents were investigated and, while action plans were developed, these were not always reflected in care planning (refer criterion 3.2.3). A sample of adverse events reviewed also showed these were not

		always completed in relation to communication with whānau (refer criterion 1.6.3) and residents who experienced unwitnessed falls were not having neurological observations completed (refer criterion 2.2.3). Internal auditing was taking place, but this was not related to the internal audit schedule, and internal audits were not being fully followed up and nor were results used to reduce risk (refer criterion 2.2.3). Critical analysis of practices and systems, using ethnicity data, identified inequities, and the service worked to address these. Delivering high-quality care to Māori residents is supported through relevant training, tikanga policies, and access to cultural support roles internally and externally. All residents and their whānau have input into quality review of the service through care planning, satisfaction surveys and meetings. Care staff are supported to complete New Zealand Qualifications Authority (NZQA) health and wellbeing courses. The FM understood and has complied with essential notification reporting requirements. There have been 26 Section 31 notifications made to HealthCERT (Manatū Hauora) since the last audit, in relation to the change of duties for the FM (two), the exit of the clinical manager (who left the role and the role was incorporated into the role of the FM, thus indicating a change to both roles), the behaviour of a visitor (one), and for RN shortage (23 notifications, 200 shifts affected, the last notification was on 6 December 2024). They service was aware of reporting requirements to the Health Quality and Safety Commission – Te Tātū Hauora (Te Tātū Hauora) for all severity assessment code (SAC) reporting at SAC1 and SAC2, as well as pressure injury at stage 3 and above. No notifications have made to Te Tātū Hauora.
Subsection 2.3: Service management The people: Skilled, caring health care and support workers listen to me, provide personalised care, and treat me as a whole person. Te Tiriti: The delivery of high-quality health care that is culturally	PA Low	There is a documented process for determining staffing levels and skill mix to provide culturally and clinically safe care, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents as much as it is able. There

responsive to the needs and aspirations of Māori is achieved through the use of health equity and quality improvement tools. As service providers: We ensure our day-to-day operation is managed to deliver effective person-centred and whānau-centred services.		has been a shortage of RN cover in the facility since the previous audit. The facility is having difficulty recruiting and retaining RNs and has been unable to fully staff the facility 24/7 with RNs as required by its contract with Te Whatu Ora (refer criterion 2.3.1). Staff reported that staff numbers (with the exception of RNs) were adequate to allow them to complete the work allocated to them. Residents and whānau interviewed supported this. At least one staff member on duty has a current first aid certificate. A multidisciplinary team (MDT) approach ensures service delivery goals are met, although not all service delivery goals are fully documented in care plans (refer criterion 3.2.3); staff were able to describe care goals and residents and their whānau interviewed were satisfied that these were being met. The employment process, which includes a job description defining the skills, qualifications and attributes for each role, ensures services are delivered to meet the needs of residents. Continuing education is planned on an annual basis and includes mandatory training requirements. Related competencies are assessed and support equitable service delivery and the ability to maximise the participation of people using the service and their whānau. High-quality Māori health information is accessed and used to support training and development programmes, policy development, and care delivery. Records reviewed demonstrated completion of the required training and competency assessments. Staff reported feeling well supported and safe in the workplace. There are policies and procedures in place around wellness, bullying and harassment.
Subsection 2.4: Health care and support workers The people: People providing my support have knowledge, skills, values, and attitudes that align with my needs. A diverse mix of people in adequate numbers meet my needs. Te Tiriti: Service providers actively recruit and retain a Māori health workforce and invest in building and maintaining their capacity and	FA	Human resources management policies and processes are based on good employment practice and relevant legislation. A sample of seven staff records reviewed confirmed the organisation's policies are being consistently implemented. Professional qualifications for health care professionals had been validated during recruitment and then checked and documented annually. Police vetting and reference checking were in place. Job descriptions were

capability to deliver health care that meets the needs of Māori. As service providers: We have sufficient health care and support workers who are skilled and qualified to provide clinically and culturally safe, respectful, quality care and services.		documented for each role across the organisation. The job descriptions described the skills and knowledge required of each position, and identified the outcomes, accountability, responsibilities, authority, and functions to be achieved. Staff reported that the induction and orientation programme prepared them well for the role, and evidence of this was seen in files reviewed. Opportunities to discuss and review performance occur annually, as confirmed in records reviewed. Staff described the performance review process as useful for them, allowing them to set their own career and education goals. There were staff wellbeing policies in place and staff were aware of these. Staff confirmed that debrief and support was available to them following any incidents. Staff information, including ethnicity data, was accurately recorded, held confidentially, and used in line with the Health Information Standards Organisation (HISO) requirements.
Subsection 2.5: Information The people: Service providers manage my information sensitively and in accordance with my wishes. Te Tiriti: Service providers collect, store, and use quality ethnicity data in order to achieve Māori health equity. As service provider: We ensure the collection, storage, and use of personal and health information of people using our services is accurate, sufficient, secure, accessible, and confidential.	FA	Mt Herbert maintained quality records that complied with relevant legislation, health information standards and professional guidelines. Resident and staff information is now mostly held electronically (the facility moved to an electronic system in October 2024), and this was username and password protected. Electronic and any remaining paper-based 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. Residents' files reviewed were integrated across the (residual) paper and electronic systems; most information and data relevant to the residents was on the electronic system. 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.

		Files for residents and staff were being held safely and securely for the required period before being destroyed. No personal or private resident information was on public display during the audit. Mt Herbert is not responsible for the National Health Index registration of people receiving services.
Subsection 3.1: Entry and declining entry The people: Service providers clearly communicate access, timeframes, and costs of accessing services, so that I can choose the most appropriate service provider to meet my needs. Te Tiriti: Service providers work proactively to eliminate inequities between Māori and non-Māori by ensuring fair access to quality care. As service providers: When people enter our service, we adopt a person-centred and whānau-centred approach to their care. We focus on their needs and goals and encourage input from whānau. Where we are unable to meet these needs, adequate information about the reasons for this decision is documented and communicated to the person and whānau.	FA	Residents were admitted to Mt Herbert when they had been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) agency as requiring the level of care the service provides, and when they had chosen the facility to provide services they required. Residents and whānau interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission, including for residents who identify as Māori. Ten resident files reviewed met contractual requirements. Mt Herbert collected ethnicity data on entry and decline rates; this included specific data for entry and decline rates for Māori. Where a prospective resident is declined entry, there are processes for communicating the decision to the person and their whānau. The service has developed partnerships with Māori communities and organisations and supports Māori and their whānau when entering the service. When admitted, residents are supported to have a choice over who will oversee their medical requirements. However, the two medical centres in the region have 'closed their books' to new residents. Mt Herbert, at the time of audit, was unable to accept new admissions to the facility as it is unable to provide the resident with the required access to medical input. The facility is in the process of negotiating a proposal to address this. It is consulting with Te Whatu Ora to fund a nurse practitioner (NP) who would work between Te Whatu Ora and Mt Herbert to supply medical oversight. This plan, if approved, means the NP would operate under the guidance of Te Whatu Ora's clinical nurse specialist-gerontology and the geriatrician. Currently a specialist team from Te Whatu Ora visits Mt Herbert fortnightly to support the GPs, in addition to that of a visiting pharmacist, who reviews residents'

		medications.
Subsection 3.2: My pathway to wellbeing The people: I work together with my service providers so they know what matters to me, and we can decide what best supports my wellbeing. Te Tiriti: Service providers work in partnership with Māori and whānau, and support their aspirations, mana motuhake, and whānau rangatiratanga. As service providers: We work in partnership with people and whānau to support wellbeing.	PA Moderate	Mt Herbert manages several residents with complex needs. The multidisciplinary team at Mt Herbert works to support the resident's wellbeing, within the constraints imposed by the limited GP services available. A care plan, based on the provider's model of care, is developed by suitably qualified staff 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. At the time of audit, Mt Herbert was in the process of changing from a paper-based resident management system to an electronic one. A review of 10 resident files identified that residents' strengths, goals and aspirations were, at times, not documented and did not align with people's values and beliefs. The support required to achieve residents' goals is also not clearly documented and communicated. Early warning signs and risks, with a focus on prevention or escalation for appropriate interventions, were not consistently recorded. This is an area requiring attention (refer criterion 3.2.3). Residents who had experienced an unwitnessed fall did not have neurological observations undertaken (refer criterion 2.2.3). This was evidenced in documentation, observation and interviews. Assessment is based on a range of clinical assessments and includes resident and whānau input (as applicable). Timeframes for the initial assessment, initial medical practitioner assessment, initial care plan, long-term care plan, and review timeframes meet contractual requirements. However, timeframes for ongoing medical practitioner and pharmaceutical reviews do not meet contractual requirements. Management of any specific medical conditions or updated medical reviews was not well documented. This is also required to be addressed (refer criterion 3.2.1). Staff understood and support Māori and whānau to identify their own pae ora outcomes in their care plan. This was verified by sampling residents' records, and from interviews of clinical staff, people receiving services and whānau.

		Where medical conditions were well documented, evidence was sighted of systematic monitoring and regular evaluation of responses to planned care, including the use of a range of outcome measures. Where progress was different to that expected, changes were made to the care plan. Residents confirmed involvement in the process. Tāngata whaikaha participate in service development through ongoing discussion. Examples of choices and control over service delivery were discussed with staff, tāngata whaikaha and whānau. Tāngata whaikaha and their whānau can independently access information. At interview with one of the five GPs who services Mt Herbert, the GP expressed satisfaction with the service, noting that at times they were dealing with extremely complex residents. Interviews with an additional five whānau of other residents expressed a high degree of satisfaction with the care provided at Mt Herbert; however, three also expressed a wish for improved communication to occur (refer criterion 1.6.3). The residents interviewed verified they were engaged in planning their care and any ongoing discussions. Whānau of residents who identified as Māori, and the Māori Health liaison officer from Te Whatu Ora, were complimentary of the cultural support provided by Mt Herbert and the responsiveness of staff to residents' needs.
Subsection 3.3: Individualised activities The people: I participate in what matters to me in a way that I like. Te Tiriti: Service providers support Māori community initiatives and activities that promote whanaungatanga. As service providers: We support the people using our services to maintain and develop their interests and participate in meaningful community and social activities, planned and unplanned, which are suitable for their age and stage and are satisfying to them.	FA	The activities programme at Mt Herbert supported residents to maintain and develop their interests and was suitable for their age and stage of life. There is one activities staff member who provides activities at Mt Herbert five days per week. The activities programme was observed as being the central focus of the daily routine at Mt Herbert. Residents were observed to be well engaged and enthusiastic about the programme being provided, and whānau were encouraged to participate when they visited. Activity assessments and plans identify individual interests and

		consider the person's identity. Individual and group activities reflected residents' goals and interests, ordinary patterns of life, and included normal community activities. Opportunities for Māori and whānau to participate in te ao Māori were facilitated. Community initiatives met the needs of Māori. Feedback on the programme is provided through resident feedback, resident meetings, and involvement in activities. Resident meeting minutes and resident interviews confirmed residents find the programme meets their needs.
Subsection 3.4: My medication The people: I receive my medication and blood products in a safe and timely manner. Te Tiriti: Service providers shall support and advocate for Māori to access appropriate medication and blood products. As service providers: We ensure people receive their medication and blood products in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Moderate	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 not, however, observed on the day of audit (refer criterion 3.4.2). All staff who administer medicines had been assessed as competent to perform the function they managed. Medication reconciliation occurs. All medications sighted were within current use-by dates. Medicines were stored safely, including controlled drugs. The required stock checks had been completed. Medicines stored were within the recommended temperature range. Prescribing practices met 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. Standing orders were not used. Self-administration of medication was facilitated and managed safely. Residents, including Māori residents and their whānau, are supported to understand their medications. The use of Māori medicines (rongoā) was facilitated. Where there were difficulties accessing medications, this was identified, and support provided. An initiative implemented a year ago to assist the GPs serving Mt Herbert in medicine management in aged care residents remains in

		place. A pharmacist employed by Te Whatu Ora visits Mt Herbert weekly and reviews the residents' medication charts. Any adjustments needed are documented and forwarded to the resident's GP for consideration. The pharmacist has direct access to any recent inpatient notes and can ensure any medication changes are being implemented. The pharmacist has guidance from the Te Whatu Ora geriatrician and the clinical nurse specialist who visit Mt Herbert every two weeks to provide support. The initiative has been deemed to be successful, with a reduction in polypharmacy and over-prescribing noted; however, a formal evaluation on the effectiveness of this initiative had not been documented.
Subsection 3.5: Nutrition to support wellbeing The people: Service providers meet my nutritional needs and consider my food preferences. Te Tiriti: Menu development respects and supports cultural beliefs, values, and protocols around food and access to traditional foods. As service providers: We ensure people's nutrition and hydration needs are met to promote and maintain their health and wellbeing.	FA	The food service at Mt Herbert was in line with recognised nutritional guidelines for people using the services. The menu was reviewed by a qualified dietitian on 3 November 2024. Recommendations made at that time have been implemented. All aspects of food management comply with current legislation and guidelines. A verification audit of the food control plan was undertaken on 8 May 2024. Twelve areas requiring attention were identified. These have been addressed and signed off. The food control plan was verified for 18 months. A reaudit of the plan is due on 8 November 2025. Each resident has a nutritional assessment on admission to the facility. Personal food preferences, any special diets and modified texture requirements are accommodated in the daily meal plan. Māori and their whānau have menu options that are culturally specific to te ao Māori. Evidence of resident satisfaction with meals was verified by residents and whānau interviews, satisfaction surveys and resident meeting minutes. Residents were given sufficient time to eat their meals in an unhurried fashion and those requiring assistance had this provided with dignity.

Subsection 3.6: Transition, transfer, and discharge The people: I work together with my service provider so they know what matters to me, and we can decide what best supports my wellbeing when I leave the service. Te Tiriti: Service providers advocate for Māori to ensure they and whānau receive the necessary support during their transition, transfer, and discharge. As service providers: We ensure the people using our service experience consistency and continuity when leaving our services. We work alongside each person and whānau to provide and coordinate a supported transition of care or support.	FA	Transfer or discharge to and from the service is planned and managed safely with coordination between services and in collaboration with the resident and 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. Whānau of residents who had experienced a transfer of their relative reported, at interview, that they were kept well informed during the transfer.
Subsection 4.1: The facility The people: I feel the environment is designed in a way that is safe and is sensitive to my needs. I am able to enter, exit, and move around the environment freely and safely. Te Tiriti: The environment and setting are designed to be Māori-centred and culturally safe for Māori and whānau. As service providers: Our physical environment is safe, well maintained, tidy, and comfortable and accessible, and the people we deliver services to can move independently and freely throughout. The physical environment optimises people's sense of belonging, independence, interaction, and function.	FA	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. There are areas external to the facility for leisure activities with appropriate seating and shade. 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 smaller private spaces for residents and their whānau. 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. Rooms for residents requiring hospital level care allowed space for the use of moving and handling equipment. Rooms were personalised according to the residents' preferences. All rooms have a window allowing for natural light, with safety catches for security. The facility is heated electronically, and this can be adjusted depending on the season and outside temperature. Space is available for the storage and charging of electronic mobility aids.

		There are adequate numbers of accessible bathroom and toilet facilities throughout the facility, including for staff and visitors. All rooms, bathrooms and communal areas have appropriately situated call bells, and these were noted to be near to residents when they were in their rooms. Call bell monitoring is part of the internal audit schedule. The building has a building warrant of fitness which expires on 1 April 2025. A planned maintenance schedule includes electrical testing and tagging, resident equipment checks, and calibrations of clinical equipment. Monthly hot water tests were completed for resident areas; these were sighted and were all within normal limits. 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. The provider intended to build a 10-bed extension onto the existing facility in 2024, but this did not occur due to the difficulty in accessing general practitioner services. The service is now planning to create a secure dementia care area for up to 20 residents. This will take the form of a secure village for residents assessed as requiring secure dementia services. There are six houses within the space allocated to the village. Five of these are four-bedroomed houses, with a plan to house four residents in each of them with staff oversight. Each house will have a kitchen, bathroom and lounge area and the residents will have a bedroom each. The sixth house will become a leisure centre and, as well as communal lounge space, will house a café, a shop, a space for hairdressing, and a laundry area. Kaylex Care directors and the FM at Mt Herbert were aware of the requirement to consult and co-design with Māori throughout the project.
Subsection 4.2: Security of people and workforce The people: I trust that if there is an emergency, my service provider will ensure I am safe. Te Tiriti: Service providers provide quality information on emergency	FA	The fire evacuation plan was approved by Fire and Emergency New Zealand (FENZ) on 16 June 2003. The requirements of the fire and emergency scheme are reflected in the facility's fire and emergency management plan. Staff have been trained in fire and emergency

and security arrangements to Māori and whānau. As service providers: We deliver care and support in a planned and safe way, including during an emergency or unexpected event.		management and knew what to do in an emergency. A fire evacuation drill is held six-monthly; the most recent drill was on 28 November 2024. Disaster and civil defence plans and policies direct the facility in its preparation for disasters and described the procedures to be followed. Staff have received relevant information and training and have appropriate equipment to respond to emergency and security situations. Adequate supplies for use in the event of a civil defence emergency meet The National Emergency Management Agency recommendations for the region, and alternative essential energy and utility sources are available in the event of the main supplies failing. Information on emergency and security arrangements is provided to residents and their whānau on entry to the service. Eleven (11) staff have current first aid certification and there was a first aid certified staff member on duty 24/7 on the rosters sighted. Call bells alert staff to residents requiring assistance. Residents and whānau reported staff respond promptly to call bells. Appropriate security arrangements are in place. The facility has overnight 'lock-up' procedures which allow for emergency egress. Staff were noted to be wearing uniforms during the audit, but not name badges (refer criterion 1.6.3).
Subsection 5.1: Governance The people: I trust the service provider shows competent leadership to manage my risk of infection and use antimicrobials appropriately. Te Tiriti: Monitoring of equity for Māori is an important component of IP and AMS programme governance. As service providers: Our governance is accountable for ensuring the IP and AMS needs of our service are being met, and we participate in national and regional IP and AMS programmes and respond to relevant issues of national and regional concern.	FA	Mt Herbert has a suite of infection prevention and control (IPC), and antimicrobial stewardship (AMS) policies outlined in its policy documents. The infection prevention (IP) and antimicrobial stewardship (AMS) programmes are appropriate to the size and complexity of the service, have been approved by the service directors, link to the quality improvement system and are reviewed and reported on monthly. Infection prevention (IP) and AMS activities are being supported at governance level through an infection coordinator (IC), who is an RN, and who makes sure that IP and AMS are being appropriately managed. Expertise and advice are available as required following

		a defined process, and this also includes escalation of significant events. Data on infections and antimicrobial use includes ethnicity data to support equity in IPC and AMS programmes, and this is reported at governance level. When clinically indicated, clinical staff at Mt Herbert can access IP and AMS expertise through the GPs/NPs associated with the service, the Te Whatu Ora infection prevention and control (IPC) nurse specialists, and Regional Public Health.
Subsection 5.2: The infection prevention programme and implementation The people: I trust my provider is committed to implementing policies, systems, and processes to manage my risk of infection. Te Tiriti: The infection prevention programme is culturally safe. Communication about the programme is easy to access and navigate and messages are clear and relevant. As service providers: We develop and implement an infection prevention programme that is appropriate to the needs, size, and scope of our services.	FA	The IC is responsible for overseeing and implementing the IP programme, with reporting lines to senior management or the governance group. The IC has appropriate skills, knowledge and qualifications for the role and confirmed access to the necessary resources and support. Their advice has been sought when making decisions around procurement relevant to care delivery, design of any new building or facility changes, and policies. The infection prevention and control policies reflected the requirements of the standard and are based on current accepted good practice. Cultural advice is accessed where appropriate. Staff were familiar with policies through orientation and ongoing education 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 are available in te reo Māori. A pandemic/infectious diseases response plan is documented and has been regularly evaluated. There are sufficient resources and personal protective equipment (PPE) available, and staff have been trained in their use. Staff were familiar with policies for decontamination of reusable medical devices and there was evidence of these being appropriately decontaminated and reprocessed. The process has been audited to maintain good practice. Single-use medical devices are not reused at Mt Herbert.

Subsection 5.3: Antimicrobial stewardship (AMS) programme and implementation The people: I trust that my service provider is committed to responsible antimicrobial use. Te Tiriti: The antimicrobial stewardship programme is culturally safe and easy to access, and messages are clear and relevant. As service providers: We promote responsible antimicrobials prescribing and implement an AMS programme that is appropriate to the needs, size, and scope of our services.	FA	Responsible use of antimicrobials is promoted. The AMS programme is appropriate for the size and complexity of the service, supported by policies and procedures. The effectiveness of the AMS programme is evaluated by monitoring antimicrobial use and identifying areas for improvement.
Subsection 5.4: Surveillance of health care-associated infection (HAI) The people: My health and progress are monitored as part of the surveillance programme. Te Tiriti: Surveillance is culturally safe and monitored by ethnicity. As service providers: We carry out surveillance of HAIs and multi-drug-resistant organisms in accordance with national and regional surveillance programmes, agreed objectives, priorities, and methods specified in the infection prevention programme, and with an equity focus.	FA	Surveillance of health care-associated infections (HAIs) is appropriate to that recommended for the type of services offered and is in line with risks and priorities defined in the infection control programme. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff and the directors of the service. Surveillance data includes ethnicity data. Communication between service providers and residents experiencing a health care-associated infection (HAI) was clear and culturally safe. Evidence verified three small COVID-19 outbreaks occurred in 2024, in addition to a Norovirus outbreak in October 2024. The Norovirus outbreak lasted for six weeks and was difficult to manage. Expert advice was sought from local Te Whatu Ora infection control advisors. The strain was identified as one that was rare and complex. Specialist cleaning regimes were employed to manage the outbreak as per specialist advice.
Subsection 5.5: Environment The people: I trust health care and support workers to maintain a hygienic environment. My feedback is sought on cleanliness within	FA	A clean and hygienic environment supports prevention of infection and transmission of antimicrobial-resistant organisms. Staff follow documented policies and processes for the

the environment. Te Tiriti: Māori are assured that culturally safe and appropriate decisions are made in relation to infection prevention and environment. Communication about the environment is culturally safe and easily accessible. As service providers: We deliver services in a clean, hygienic environment that facilitates the prevention of infection and transmission of antimicrobialresistant organisms.		management of waste and infectious and hazardous substances. Laundry and cleaning processes are monitored for effectiveness. Staff involved have completed relevant training and were observed to perform duties safely. Chemicals were stored safely. Residents and whānau reported that the laundry is managed well, and the facility is kept clean and tidy. This was confirmed through observation. The IC role has oversight of the facility testing and monitoring of the built environment.
Subsection 6.1: A process of restraint The people: I trust the service provider is committed to improving policies, systems, and processes to ensure I am free from restrictions. Te Tiriti: Service providers work in partnership with Māori to ensure services are mana enhancing and use least restrictive practices. As service providers: We demonstrate the rationale for the use of restraint in the context of aiming for elimination.	FA	A restraint-free environment is the aim of the service, and this is documented in the facility's policy. The directors of the service interviewed demonstrated their commitment to this and the facility and is working with residents and their whānau to achieve this. At the time of audit, four residents were reported to be using a restraint, although observation through the audit showed that the four residents were using six restraints between them (refer criterion 6.2.1). There are strategies in place in the service to eliminate restraint, including an investment in equipment to support the removal of restraint (e.g., through the use of 'intentional rounding' (scheduled resident checks), high/low beds, and sensor equipment). Documentation confirmed that aggregated information on restraint use is discussed at facility level and as part of the facility's clinical reporting to the directors of the service. The restraint coordinator (RC) is a defined role undertaken by a RN who provides support and oversight of restraint use. There is a job description that outlines the role, and the RC has had specific education around restraint and its use. The RC, in consultation with the GP and the multidisciplinary team, is responsible for the approval of the use of restraint; there are clear lines of accountability. For any decision to use or not use restraint, there is a process to involve the resident, their EPOA and/or whānau as part of the decision-making and consent process.

		The restraint committee continues to maintain a restraint register; the criteria on the restraint register contained enough information to provide a record of restraint use for four of six restraints in use (refer criterion 6.2.4). Restraint is considered during the individualised care planning process, but this is not fully documented in the care plans of the residents using a restraint (refer criterion 6.2.4). Restraint is considered only when all other interventions have failed. Any changes to policies, guidelines, education and processes are implemented if indicated. There are processes in place for emergency restraint in policy should this be required. Staff have been trained in the management of behaviours that challenge, least restrictive practice, safe restraint practice, alternative cultural-specific interventions, and de-escalation techniques as part of orientation, and through the education programme. Restraint use is identified as part of the quality programme.
Subsection 6.2: Safe restraint The people: I have options that enable my freedom and ensure my care and support adapts when my needs change, and I trust that the least restrictive options are used first. Te Tiriti: Service providers work in partnership with Māori to ensure that any form of restraint is always the last resort. As service providers: We consider least restrictive practices, implement de-escalation techniques and alternative interventions, and only use approved restraint as the last resort.	PA Moderate	When restraint is used, this is as a last resort when all alternatives have been explored. Observation during the audit showed that six restraints were in use for four residents. Restraint records showed that four restraints had been consented for four residents and two had not; two residents were using two restraints that were not consented (refer criterion 6.2.1). Four of the six restraints had an assessment in place, but assessment did not include cultural considerations (refer criterion 6.2.1). On the consent and assessment forms, there was evidence of whānau involvement in the processes. The resident's GP was also involved in the restraint process. Access to advocacy is facilitated, as necessary. Monitoring of restraint is overseen by the RC and takes into consideration the person's physical, psychological and psychosocial needs and addresses wairuatanga. Monitoring, however, was not being completed to the requirements assessed for the residents and in five of the six restraints in use, the frequency of restraint was not documented (refer criterion 6.2.2).

		A restraint register is maintained and reviewed at each restraint approval group meeting. The register contained enough information to provide an auditable record for four of six restraints in use, including all requirements of the standard, and two of the restraints were not documented on the restraint register (refer criterion 6.2.4). Care plans of residents using restraint did not have all of the requirements of the Standard; two of the restraints were not documented and only one plan had monitoring requirements documented. Only one of the restraints required evaluation, the others having been initiated only recently. Evaluation of the restraint had taken place, but the evaluation was in a 'progress notes' format and did not take into account all the requirements of the Standard (refer criterion 6.2.7). No emergency restraint has been used by the service but the protocols for this have been described in policy and can only be used in extreme circumstances (in the event of a potential serious injury to the resident or another person). Emergency restraint would be reported as a significant event and debrief would be available following the event.
Subsection 6.3: Quality review of restraint The people: I feel safe to share my experiences of restraint so I can influence least restrictive practice. Te Tiriti: Monitoring and quality review focus on a commitment to reducing inequities in the rate of restrictive practices experienced by Māori and implementing solutions. As service providers: We maintain or are working towards a restraint-free environment by collecting, monitoring, and reviewing data and implementing improvement activities.	PA Moderate	The restraint committee meets three-monthly. At the restraint meeting, each person using a restraint is discussed; ethnicity is documented for residents using restraint (with the exception of two restraints, a lap belt and vest harness, which were undocumented). Monthly reporting includes restraint use (again with the exception of the two undocumented restraints). Policies and procedures are sourced from an external source and updated by them if change is indicated. The restraint committee does not, however, undertake a six-monthly review of all restraint use that includes all the requirements of the standard (refer criterion 6.2.3). The use of restraint has increased from one to six since the last (certification) audit, but the acuity of residents using restraints supports the increase.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.6.3 My service provider shall practise open communication with me.	PA Moderate	Residents reported that communication was open and effective, and they felt listened to. Interviews with five of seven whānau identified that communication at Mt Herbert was a concern for them. They reported that they were often not informed of a change in a resident’s condition, following updates from a doctor’s visit or when incidents had occurred. They said that they only found out when alerted during a visit to the facility. A review of 10 incident/accident forms, covering resident incidents or accidents, included no documentation acknowledging whānau had been informed. A review of progress notes covering that period also	Mt Herbert staff do not always keep whānau informed of medical updates, incidents or accidents that have occurred or changes in the residents’ conditions. Residents, visitors and whānau are often unaware of the name of staff members they are communicating with.	Provide evidence that Mt Herbert is keeping whānau informed of changes in the resident’s condition, medical updates, and any incidents or accidents that have occurred. Ensure residents, whānau and visitors have a means to identify which staff member they are taking to. 30 days

		verified no evidence to support that whānau had been notified. A request by a GP during the onsite audit, to increase the monitoring of a particular aspect of a resident's care, was not notified to the resident's whānau at the time it was requested, until it was suggested this happen. Staff did not wear name badges. Visitors, residents and whānau were often not aware of the name of the staff member they were dealing with.		
Criterion 2.2.3 Service providers shall evaluate progress against quality outcomes.	PA Moderate	The service is currently transitioning from a paper-based internal audit schedule to an electronic schedule. The transition commenced towards the end of October 2024. Some internal audits were completed in 2024 and 2025 but not to the published internal audit schedule of either method. On the paper-based system, seven audits not on the schedule were completed and 15 audits on the schedule were not. Nearly all the audits were rated as 100%. Discussion of this showed that the method being used was to carry out the audit, fix any issues and then mark the audit as complete, rather than generating corrective actions and reporting against these (as required in policy). There was no documentation on the corrective	The internal audit schedule has not been adhered to, and not all internal audits have been fully completed with corrective actions generated and addressed as required through policy. There was no record of neurological observation having been fully completed following unwitnessed falls.	Provide evidence that the internal audit schedule is being adhered to, with findings and corrective actions documented and addressed. Provide evidence that unwitnessed falls are having neurological observations fully completed. 60 days

		actions addressed through this process to allow for trending. Since the electronic system has been introduced, the service has been 'practising' with the internal audit system and reported they are starting to 'get to grips' with it. Ten audits have been conducted through the electronic system (including infection prevention and control, antimicrobial stewardship, and restraint); however, not all have 'findings' documented. Despite this, corrective actions were recorded, indicating the system is not yet being used correctly. Added to this, when adverse events for unwitnessed falls (three between October and December 2024) were documented, not all unwitnessed falls had neurological observation fully completed. All of the unwitnessed falls had initial observations completed but not all included neurological assessment (e.g., pupil reaction and size) and none had a record of neurological observation being fully completed.		
Criterion 2.3.1 Service providers shall ensure there are sufficient health care and support workers on duty at all times to provide culturally and	PA Low	The service is continuing to have difficulty recruiting and retaining RNs and not all shifts had been covered by RNs (as required by the service's contract with Te Whatu Ora) on the rosters sighted. Over the last year, 23 Section 31	Not all shifts at the facility are covered by an RN as required under the service's contract with Te Whatu Ora. There are insufficient RNs employed to cover RN leave.	Provide evidence that sufficient numbers of RNs are employed to cover the facility 24/7 including when RN staff are on leave.

clinically safe services.		notifications have been made to Manatū Hauora in relation to RN cover, the last being in December 2024. The number of shifts not covered has been reducing through 2024 and into 2025 and currently there is only difficulty when RN staff are on leave. On the four weeks of roster reviewed in detail for this audit, seven shifts were not covered. One was for an afternoon shift and six for night shifts. The facility has contingency plans in place when there is no RN on shift through an enrolled nurse (EN), and senior health care assistants (HCAs) who are medication competent. On-call RN services are also in place; the RN on-call service is within 10 minutes travel to the facility and can attend if this is needed.		180 days
Criterion 3.2.1 Service providers shall engage with people receiving services to assess and develop their individual care or support plan in a timely manner. Whānau shall be involved when the person receiving services requests this.	PA Low	A care plan, based on the provider's model of care, was developed by suitably qualified staff following a comprehensive assessment. A review of 10 resident files identified the residents had not been seen by a GP within the last three months. A proposal, in consultation with Te Whatu Ora, to rectify this situation is currently being considered. For this reason, the risk is identified as low. Three residents had not had their medications reviewed in the	People receiving services at Mt Herbert are not always receiving medical and pharmaceutical review services within the required timeframes, and interRAI assessments were not being completed as required.	Provide evidence residents receive medical services, a review of their medications and an up-to-date interRAI assessment within the required timeframes. 180 days

		past three months. Three of eight residents requiring interRAI assessments had not had these completed within the past six months.		
Criterion 3.2.3 Fundamental to the development of a care or support plan shall be that: (a) Informed choice is an underpinning principle; (b) A suitably qualified, skilled, and experienced health care or support worker undertakes the development of the care or support plan; (c) Comprehensive assessment includes consideration of people's lived experience; (d) Cultural needs, values, and beliefs are considered; (e) Cultural assessments are completed by culturally competent workers and are accessible in all settings and circumstances. This includes traditional healing practitioners as well as rākau rongoā, mirimiri, and karakia; (f) Strengths, goals, and aspirations are described and align with people's values and beliefs. The support required to achieve these is clearly documented and communicated; (g) Early warning signs and risks that may adversely affect a	PA Moderate	On admission to Mt Herbert, the resident's care plan, based on one of the provider's models of care, was developed by suitably qualified staff following a comprehensive assessment, including consideration of the person's lived experience, cultural needs, values, and beliefs, and which considers wider service integration, where required. A review of 10 files, recently updated in a move to a new electronic system, identified that the care plans did not consistently nor fully describe the care the residents required to meet their needs. A resident with a recent issue of hypotension related to dehydration had no nursing interventions described to prevent further recurrence. A resident with ongoing nausea had no management plan in place to manage this, despite the RN verbally being able to identify potential causes that were being monitored. A resident with a pressure injury did not have the strategies to minimise these occurring documented, nor	Care plans reviewed did not describe fully all the care the residents require to address their needs. Early warning signs that may adversely affect a resident's wellbeing were not always being recorded.	Provide evidence that care plans fully describe all the care the residents require to address their needs, and that early warning signs that may adversely affect a resident's wellbeing are recorded and being monitored. 90 days

person's wellbeing are recorded, with a focus on prevention or escalation for appropriate intervention; (h) People's care or support plan identifies wider service integration as required.		reference to a wound care plan, despite there being one in place. A resident with a history of congestive heart failure had no interventions identified that would indicate early warning signs of a deterioration. A resident requiring specific support for a previous injury did not have mention in the care plan that this was required. Residents requiring a bedrail or lap belt to ensure their safety had no documentation in the care plan to identify how this was to be safely managed (refer subsection 6.2).		
Criterion 3.4.2 The following aspects of the system shall be performed and communicated to people by registered health professionals operating within their role and scope of practice: prescribing, dispensing, reconciliation, and review.	PA Moderate	The medication management policy at Mt Herbert 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, except for the practice observed around the administration of controlled drugs (CD) in liquid form. The CD medications for two residents were observed to have been checked out by two persons, one being an RN and the other being a medication competent HCA. The correct dosages were dispensed and the correct calculations signed for in the CD register. However, both staff members did	The administration of CD liquids at Mt Herbert, during the observed medication round, was not consistent with best practice guidelines.	Provide evidence that CD medications are checked out by two people who then both go to the resident to ensure the right resident receives the right medication. 30 days

		not go to the residents to verify the correct drugs had been administered to the correct resident. The potential for error was not identified by either party. The FM and senior RN (who is assisting the FM with clinical oversight of the facility) agreed to address this practice and ensure second checkers are aware of their responsibility to ensure the correct person receives the correct medication. Further investigation identified non-liquid CDs were administered with the two checkers going to the bedside. In addition, on investigation by the senior RN it was found the electronic system at the time did not allow for signing by two parties when these medicines were administered. This has been addressed by the contracted service.		
Criterion 6.2.1 The decision to approve restraint for a person receiving services shall be made: (a) As a last resort, after all other interventions or de-escalation strategies have been tried or implemented; (b) After adequate time has been given for cultural assessment; (c) Following assessment, planning, and preparation, which	PA Moderate	Observation during the audit showed that six restraints were in use for four residents. Of the documented restraints (four), one was a lap belt and three were bedrails. Two of the residents were sighted to be using two further restraints, both had a consent in place for a bed rail but one was observed to be using a lap belt and another a vest harness; neither of these had	Consents were not in place for two of six restraints in use, and cultural considerations had not been taken into account during restraint assessment.	Provide evidence that all restraints are consented for prior to use and that the resident's culture is considered as part of the restraint process. 30 days

includes available resources able to be put in place; (d) By the most appropriate health professional; (e) When the environment is appropriate and safe.		consents in place. The facility responded promptly to the consent issue and initiated processes around the consent of the two restraints with the GP and whānau of residents prior to the end of the audit. Four of the six restraints had an assessment in place, but assessments did not include cultural considerations.		
Criterion 6.2.2 The frequency and extent of monitoring of people during restraint shall be determined by a registered health professional and implemented according to this determination.	PA Moderate	The requirement for monitoring restraint is set out in policy, with a requirement that monitoring be no less than two-hourly. The policy requires that a RN assess the appropriate monitoring for each restraint, dependent on risk to the resident. The monitoring frequency and extent was in place for one resident, set at half-hourly. Monitoring frequency and extent was not documented for any of the other restraints in use, including the two (lap belt and vest harness) which were in use and undocumented. Records reviewed showed that, while some monitoring had taken place, the monitoring did not meet the requirements assessed where documented for one resident (half-hourly), nor the requirements set in policy (at least two-hourly) for the remainder. Two undocumented restraints had no	The frequency and extent of monitoring of residents during restraint was not determined by the RN for all restraints in use as required by policy. Where the frequency and extent of monitoring of residents was determined, either by the RN or through the policy requirements, the monitoring regime had not been adhered to. Five of six restraints in use did not have monitoring requirements recorded in their records.	Ensure the frequency and extent of monitoring of residents using restraint is documented and that monitoring is implemented when residents are using a restraint. 60 days

		monitoring (the lap belt and vest harness).		
Criterion 6.2.4 Each episode of restraint shall be documented on a restraint register and in people's records in sufficient detail to provide an accurate rationale for use, intervention, duration, and outcome of the restraint, and shall include: (a) The type of restraint used; (b) Details of the reasons for initiating the restraint; (c) The decision-making process, including details of de-escalation techniques and alternative interventions that were attempted or considered prior to the use of restraint; (d) If required, details of any advocacy and support offered, provided, or facilitated; NOTE – An advocate may be: whānau, friend, Māori services, Pacific services, interpreter, personal or family advisor, or independent advocate. (e) The outcome of the restraint; (f) Any impact, injury, and trauma on the person as a result of the use of restraint; (g) Observations and monitoring of the person during the restraint; (h) Comments resulting from the evaluation of the restraint; (i) If relevant to the service: a	PA Moderate	A restraint register was in place that documented four from six restraints in use; two restraints in use (lap belt and vest harness) were not documented on the restraint register. Four of six restraints in use were documented in the residents' care plan but not in sufficient detail to provide an accurate rationale for use, intervention, duration, and outcome of the restraint, nor were the risks of using the restraints with associated interventions to prevent injury, fully documented. The remaining two restraints in use were not documented. The electronic resident management system in place for residents' records has a dedicated restraint care plan in place within the system; this had not been completed for any of the restraints in use.	Not all restraints in use were documented on the restraint register. Care plans for residents using restraint did not describe in sufficient detail the rationale for use, intervention to be used, duration, and outcome of the restraint, nor were the risks of using restraints documented with associated interventions to prevent injury.	Ensure all restraints in use are documented on the restraint register. Ensure care plans are in place which outline, in sufficient detail, an accurate rationale for use, the intervention, duration of restraint, and outcome of the restraint. The risks of using the restraints are to be fully documented, with associated interventions to prevent injury. 60 days

record of the person-centred debrief, including a debrief by someone with lived experience (if appropriate and agreed to by the person). This shall document any support offered after the restraint, particularly where trauma has occurred (for example, psychological or cultural trauma).				
Criterion 6.2.7 Each episode of restraint shall be evaluated, and service providers shall consider: (a) Time intervals between the debrief process and evaluation processes shall be determined by the nature and risk of the restraint being used; (b) The type of restraint used; (c) Whether the person's care or support plan, and advance directives or preferences, where in place, were followed; (d) The impact the restraint had on the person. This shall inform changes to the person's care or support plan, resulting from the person-centred and whānaucentred approach/reflections debrief; (e) The impact the restraint had on others (for example, health care and support workers, whānau, and other people); (f) The duration of the restraint episode and whether this was the	PA Moderate	Only one of the restraints required evaluation, the others having been initiated only recently (November 2024, due February 2024 in the absence of any issues with the restraints in use). Where evaluation of the restraint had taken place, the evaluation was in a 'progress notes' format and did not include the requirements of the Standard: whether the person's care or support plan and advance directives or preferences (where in place) were followed, the impact the restraint had on the person or others, the duration of the restraint episode and whether this was the least amount of time required evidence that other de-escalation options were explored, whether appropriate advocacy or support was provided or facilitated, whether the observations and monitoring were adequate and maintained the safety of the person, future options to avoid the use of	Evaluation of the use of restraint had not been undertaken as required by the Standard.	Provide evidence that evaluation of restraint is being completed as required by the Standard. 60 days

least amount of time required; (g) Evidence that other de-escalation options were explored; (h) Whether appropriate advocacy or support was provided or facilitated; (i) Whether the observations and monitoring were adequate and maintained the safety of the person; (j) Future options to avoid the use of restraint; (k) Suggested changes or additions to de-escalation education for health care and support workers; (l) The outcomes of the person-centred debrief; (m) Review or modification required to the person's care or support plan in collaboration with the person and whānau; (n) A review of health care and support workers' requirements (for example, whether there was adequate senior staffing, whether there were patterns in staffing that indicated a specific health care and support workers issue, and whether health care and support workers were culturally competent).		restraint, suggested changes or additions to de-escalation education for health care and support workers, or review or modification required to the person's care or support plan in collaboration with the person and whānau. A review of health care and support workers' requirements had taken place as a result of human resources activity, including acuity of residents.		
Criterion 6.3.1 Service providers shall conduct comprehensive reviews at least six-monthly of all restraint	PA Moderate	There has been no six-monthly review of restraint as required by the Standard. Review has been limited to a general discussion of	Six-monthly review of the use of restraint has not taken place.	Provide evidence that six-monthly review of the use of restraint is taking place.

practices used by the service, including: (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 and support workers' feedback and current evidenced-based best practice; (h) If the person's care or support plans identified alternative techniques to restraint; (i) The person and whānau, perspectives are documented as part of the comprehensive review; (j) Consideration of the role of whānau at the onset and evaluation of restraint; (k) Data collection and analysis (including identifying changes to care or support plans and documenting and analysing learnings from each event);		residents using restraint at three-monthly restraint committee meetings. These meetings do not discuss restraint in enough detail to meet the requirements of the Standard.		90 days

(l) Service provider initiatives and approaches support a restraint-free environment; (m) The outcome of the review is reported to the governance body.				

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.