Millvale House Miramar Limited - Millvale House Miramar

Introduction

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

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

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

You can view a full copy of the standard on the Manatū Hauora website by clicking here.

The specifics of this audit included:

Legal entity:	Millvale House Miramar Limited
Premises audited:	Millvale House Miramar
Services audited:	Hospital services - Psychogeriatric services
Dates of audit:	Start date: 10 April 2025 End date: 11 April 2025

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

Total beds occupied across all premises included in the audit on the first day of the audit: 24

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 fully attained with some subsections exceeded
	No short falls	Subsections applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some subsections applicable to this service partially attained and of low risk

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

General overview of the audit

Dementia Care New Zealand Limited is the parent company of Millvale House Miramar. The service provides psychogeriatric level of care for up to 26 residents. At the time of the audit there were 24 residents.

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

The clinical manager is supported by an operations coordinator and a regional clinical manager.

There are quality systems and processes being implemented. Feedback from family/whānau was positive about the care and the services provided. An induction and in-service training programme is in place to provide staff with appropriate knowledge and skills to deliver care.

The two previous findings related to the registered nurse roster and care plan interventions remain as areas for improvement.

This surveillance audit identified shortfalls related to complaints management, statutory and legislative notifications, staff training, staff competencies, care-planning timeframes and care plan evaluations.

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 partially attained and of low risk.

A Māori health plan is in place for the organisation. Māori mana motuhake is recognised in all aspects of service delivery, using a strengths-based and holistic model of care. Staff encourage participation in te ao Māori.

A pacific health plan is in place which ensures cultural safety for Pacific peoples, embracing their worldviews, cultural and spiritual beliefs.

Policies are in place around the elimination of discrimination, harassment, and bullying. Consent forms are signed appropriately. There is an established system for the management of complaints that is responsive, fair, equitable and meets guidelines established by the Health and Disability Commissioner.

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

The business plan includes a mission statement and operational objectives. The service has a quality and risk management system in place that take a risk-based approach. Quality improvement projects are implemented. Internal audits, and collation of data were all documented as taking place as scheduled, with corrective actions as indicated.

There is a staffing and rostering policy that aims to manage human resources in accordance with good employment practice. An orientation programme and staff training plan are in place to support staff in delivering safe quality care.

Ngā huarahi ki te oranga | Pathways to wellbeing

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

The registered nurses are responsible for each stage of service provision. Resident records reviewed, provided evidence that the registered nurses utilise the interRAI assessment process. Care plans demonstrate service integration. Resident files included medical notes by the contracted general practitioner and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. There is a process to ensure staff responsible for administration of medication complete education and medication competencies. Electronic medicine charts reviewed met prescribing requirements and were reviewed at least three-monthly by the general practitioner.

The kitchen staff cater to individual cultural and dietary requirements. All food and baking is prepared and cooked on site in the kitchen. The service has a current food control plan. There are additional snacks available 24/7.

All residents' transfers and referrals occur in a coordinated manner.

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 fully attained.

The building has a current warrant of fitness. There is a planned and reactive maintenance programme in place. Equipment is maintained for electrical compliance and clinical equipment is regularly calibrated.

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

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

There is a comprehensive infection control programme in place which has been approved and reviewed by the directors. Staff complete education in relation to infection control during orientation and as scheduled annually.

Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated, and reported to relevant personnel in a timely manner. There were two outbreaks since the previous audit, and these have been well documented and notified.

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.		Subsections applicable to this service fully attained.

The restraint coordinator is a registered nurse. There were no residents using a restraint at the time of the audit. Encouraging a restraint-free environment is included as part of the education and training plan. The service considers least restrictive practices, implementing de-escalation techniques and alternative interventions, and only uses an approved restraint as the last resort.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Subsection	0	14	0	2	2	0	0
Criteria	0	41	0	5	3	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	A Māori health plan is documented for Millvale House Miramar. The plan acknowledges Te Tiriti o Waitangi as a founding document for Aotearoa New Zealand. The Māori health plan has a set of actions to address barriers to Māori accessing care and employment within Millvale House Miramar, which is understood by staff who confirmed in interview that mana motuhake is recognised. At the time of the audit there were residents who identified as Māori, and no staff were currently employed who identify as Māori.
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	There is a Pacific health plan which aligns to Ola Manuia Pacific Health and Wellbeing Action Plan 2020-2025. The aim is on fostering Pacific community integration and collaboration to enable better planning, support interventions, and evaluations of the health and wellbeing of Pacific peoples to improve outcomes. At the time of the audit there were residents who identified as Pasifika whose family/whānau supported staff in understanding worldviews, cultural and spiritual beliefs of Pacific peoples. There were staff who identified as Pasifika.

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	Details relating to the Code of Health and Disability Consumers' Rights (the Code) are included in the information that is provided to new residents and their family/whānau. The operations coordinator and clinical manager discuss aspects of the Code with residents` family/whānau on admission. The Code is displayed in multiple locations in English and te reo Māori. Three family/whānau interviewed reported that the service is upholding the residents' rights. Interactions observed between staff and residents during the audit were respectful.
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	Millvale House Miramar policies provide guidelines that aim to prevent any form of institutional racism, discrimination, coercion, harassment, or any other exploitation. A comprehensive house rules/ code of conduct is discussed and signed by staff during their induction to the service. The house rules/code of conduct addresses harassment, racism, and bullying. Staff sign to acknowledge that they accept the house rules / code of conduct as part of the employment process. All family/whānau interviewed confirmed that the staff are very caring, supportive, and respectful. The service implements a process to manage residents' comfort funds, such as sundry expenses. Professional boundaries are defined in job descriptions. Interviews with registered nurses and caregivers confirmed their understanding of professional boundaries, including the boundaries of their role and responsibilities. Professional boundaries are covered as part of orientation. Interviews with eight staff (four caregivers, two registered nurses, one cook, one home assistant), the clinical manager, operations coordinator, operations management leader, family/whānau and documentation reviewed, confirmed that the staff are very caring, supportive, and respectful.
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	FA	There are policies documented to provide guidance in relation to obtaining informed consent that reflect the requirements of the Code. Informed consent processes were discussed with family/whānau on admission. Five resident files were reviewed. Written general consents sighted for outings, photographs, release of medical information, medication management and

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.		medical cares were included and signed as part of the admission process. Specific consent had been signed by the activated enduring power of attorney (EPOA) for procedures, such as influenza and Covid-19 vaccines. The admission agreement is appropriately signed by the EPOA/Welfare Guardians. Activated enduring power of attorney documentation is filed in the residents' files. Discussions with family/whānau confirmed that they are involved in the decision-making process, and in the planning of resident's care.
Subsection 1.8: I have the right to complain The people: I feel it is easy to make a complaint. When I complain I am taken seriously and receive a timely response. Te Tiriti: Māori and whānau are at the centre of the health and disability system, as active partners in improving the system and their care and support. As service providers: We have a fair, transparent, and equitable system in place to easily receive and resolve or escalate complaints in a manner that leads to quality improvement.	PA Low	The complaints procedure is provided to family/whānau during the resident's entry to the service. Access to complaints forms is located at the entrance to the facility or on request from staff. The Code and complaints process is visible, and available in te reo Māori, and English. A complaints register is being maintained which includes all complaints, dates and actions taken. The has been three internal complaints received since the last audit in August 2023: all received in 2024. Documentation including acknowledgement, follow-up letters and resolution were completed. However, the timeframes from receipt of the complaint to resolution did not demonstrate that complaints are being managed in accordance with guidelines set by the Health and Disability Commissioner (HDC). All complaints were closed off to the satisfaction of the complainants. There have been no external complaints. Family/whānau making a complaint can involve an independent support person in the process if they choose. The complaints process is linked to advocacy services. Discussions with family/whanau confirmed that they were provided with information on the complaints process and remarked that any concerns or issues they had, were addressed promptly. Information about the support resources for Māori is available to staff to assist Māori in the complaints process. Interpreters contact details are available. The clinical manager acknowledged their understanding that for Māori, there is a preference for face-to-face communication and to include whānau participation. Staff are informed of complaints (and any subsequent corrective actions) in

		the quality meetings (meeting minutes sighted).
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	Dementia Care NZ Limited (DCNZ) is the parent company under which Millvale House Miramar operates. Millvale House Miramar provides psychogeriatric level of care for up to 26 residents. On the day of audit, there were 24 residents including one admitted under Accident Compensation Corporation (ACC) funding. All the remaining residents were under the age-related hospital specialist services (ARHSS) agreement. Dementia Care New Zealand has a corporate structure that includes two directors/owners and a governance team of managers which includes: an operations management leader, quality systems manager, public relations and marketing manager, clinical advisor, two regional clinical managers (North and South Island) and a national training coordinator. The role of Strategic Communication, Engagement and Governance Advisor is in place and guides the governance of the organisation. There are terms of reference for responsibilities at the general meeting and for the clinical governance group that reports to the general meeting. A group of advisors provide guidance to the directors this includes business advisors, the clinical governance group and customer focus groups. The guidance from these groups assist with the direction of the strategic and business plan. Barriers to providing culturally appropriate services are identified and mitigated. The Māori health advisor ensures these needs are met. DCNZ has an overarching strategic plan (2024-2027) and a related business plan 2024-2025 that is developed in consultation with managers and has been reviewed annually. The organisation's vision and values includes acceptance of all people with kindness, love, provision of peace and comfort. The management team are striving to achieve this vision with openness, honesty, integrity, and passion. The strategic plan identifies Māori equity as a principal driver for success, alongside Pacific community inclusion. Quality improvements are identified at the individual facilities and/or at an organisational level where needed. The feedback from these sources and quality improvement initiatives generated, are reported through DCNZ general meeting and steps to address issues raised are identified. DCNZ works closely with Health New Zealand to ensure service provision meets

		the needs of the local community. A regional clinical manager supports the clinical manager of each service. Where clinical issues arise, they are considered at the clinical governance meeting which the regional clinical managers attend. Issues and outcomes from the clinical governance meeting are discussed with the directors and reported through the general meeting. The day-to-day clinical operations is overseen by the clinical manager who is supported by an operations coordinator, who oversees the non-clinical part of the operations. The clinical manager has been in the role since April 2024 and has worked at DCNZ from 2022. The operations coordinator has been in the role since 2020 and at Millvale House Miramar for 14 years. The management is supported by a team of registered nurses and caregivers. The regional clinical manager, quality systems manager, national educator and an operations management leader (present on the day of the audit) also provide support for the staff at Millvale House Miramar. The managing director visits the site on a regular basis to support the management team. The clinical manager and operations coordinator have maintained the required eight hours of professional development activities related to managing an aged care facility, this includes completing role specific orientation, attending two-day professional development days for DCNZ clinical managers and operations managers/coordinators.
Subsection 2.2: Quality and risk The people: I trust there are systems in place that keep me safe, are responsive, and are focused on improving my experience and outcomes of care. Te Tiriti: Service providers allocate appropriate resources to specifically address continuous quality improvement with a focus on achieving Māori health equity. As service providers: We have effective and organisation-wide governance systems in place relating to continuous quality improvement that take a risk-based approach, and these systems meet the needs of people using the services and our health care and support workers.	PA Low	Millvale House Miramar is implementing a quality and risk management programme. The 2024 annual quality improvement goals have been reviewed, and the 2025 programme is documented and includes plans to achieve goals, target dates for implementation, responsibilities for implementation and improvement indicators. Interviews with the clinical manager confirmed their understanding and involvement in quality and risk management practices. The organisations quality and risk management programme includes performance monitoring through internal audits and through the collection of clinical indicator data. Monthly quality, health and safety, and registered nurse meetings provide an avenue for discussions in relation to (but not limited to): quality data; health and safety; infection control/pandemic strategies; complaints received (if any); cultural compliance; staffing; and

		education. Meetings were completed as scheduled and meeting minutes reviewed, evidence follow up of action and sign off when completed. Internal audits are completed as per the internal audit schedule. Any corrective actions identified are used to improve service delivery and are being signed off when resolved and discussed at meetings. Quality data is collected, analysed, and discussed at meetings. Family/whanau satisfaction are completed annually. The surveys completed in 2024 reflect overall satisfaction of the service. Survey outcomes have been communicated to the EPOAs including areas of quality improvement related to activities, food service and care planning, that the organisation is working on based on feedback received. Policies and procedures are held electronically and in hard copy. Staff interviewed confirmed they were able to access policies and relevant documentation, as and when required. Each incident/accident is documented electronically. Eleven accident/incident forms reviewed indicated that the forms are completed in full and signed off by the clinical manager; opportunities to minimise risk are documented. Incident and accident data is collated monthly and reported in the staff, quality, health and safety, and registered nurse meetings. Health and safety meetings occur monthly. Hazards and other risks are documented and addressed. There is a plan to ensure that staff receive education related to hazard management and health and safety at orientation, and annually . Discussions with the clinical manager evidenced awareness of their requirement to notify relevant authorities in relation to essential notifications. There have been section 31 and Severity Assessment Code (SAC) notifications to Health Quality and Safety Commission (HQSC) reported. However, not all events that required reporting have been completed as per requirements. Reporting sighted on the day of the audit related to three for pressure injuries, two for residents absconding and one for change in clinical manager. There have been two outbreaks since the previous audit. All the outbreaks were well managed and reported appropriately.
Subsection 2.3: Service management	PA	There is a staffing policy that describes rostering requirements for Millvale House Miramar. The roster reviewed in relation to RN cover, does not

The people: Skilled, caring health care and support workers listen to me, provide personalised care, and treat me as a whole person. Te Tiriti: The delivery of high-quality health care that is culturally responsive to the needs and aspirations of Māori is achieved through the use of health equity and quality improvement tools. As service providers: We ensure our day-to-day operation is managed to deliver effective person-centred and whānau-centred services.	Moderate	provide sufficient and appropriate coverage for the effective delivery of care and support for psychogeriatric level care residents. The service has a full complement of registered nurses; however, there continues to be an inability to provide 24/7 registered nurse cover. The previous audit shortfall related to criteria # 2.3.1 remains ongoing. The clinical manager and operations coordinator work full time Monday to Friday. The number of caregivers on each shift is sufficient for the acuity and layout of the facility to provide safe and timely care on all shifts. Family/whanau interviewed confirmed the care requirements of residents are attended to in a timely manner and there were sufficient staff on duty when they visited. The clinical manager and operations coordinator are on call 24/7. The service aims to ensure that any absences and sick leave are covered through extending working hours as mutually agreed with the employee, or use of the casual pool of staff; this was evident in the roster related to caregiver shifts. However, the non-clinical roster reviewed evidence that one member of staff worked continuously without a required rest period to cover staff absences in the kitchen. There is an annual education and training schedule being implemented for 2025. The education and training schedule lists compulsory training, which includes cultural awareness training and topics related to caring for the older person. Training is facilitated face to face and led by the DCNZ educator (also mental health registered nurse). There is an attendance register for each training session and educational topics offered, including: in-service education, competency questionnaires, online learning, and external professional development. However, not all staff have completed the required training in 2024. The organisation's orientation programme ensures core competencies and compulsory knowledge/topics are addressed. External training opportunities for care staff include training through Health New Zealand and hospice. Millvale House Miramar supports all employees to transition through the New Zealand Qualification Authority (NZQA) Careerforce Certificate for Health and Wellbeing. Of the 15 caregivers employed, 80% have achieved a level three NZQA qualification or higher. Fourteen of the fifteen staff employed have completed the required dementia and psychogeriatric unit standards. The remaining caregiver has recently been employed, is enrolled to complete the dementia unit standards and progress to complete the three

		additional psychogeriatric unit standards. All staff are required to complete competency assessments as part of their orientation and annually. However not all staff have completed the required competencies. All registered nurses have current medication competencies. Five of six registered nurses (including clinical manager) are interRAI trained. All registered nurses are encouraged to attend in-service training and complete additional training, including critical thinking; infection prevention and control, including Covid-19 preparedness and identifying and assessing the unwell resident. A record of completion is maintained on an electronic system and staff personnel file.
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 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.	FA	Five staff files reviewed (clinical manager, two care givers, one registered nurse and one cook) included evidence of completed orientation, training and competencies and professional qualifications on file where required. A register of practising certificates is maintained for all health professionals. The service has an orientation programme in place that provides new staff with relevant information for safe work practice and includes buddying when first employed. Competencies are completed at orientation. The service demonstrates that the orientation programme supports registered nurses and caregivers to provide a culturally safe environment to Māori. Caregivers interviewed reported that the orientation process prepared new staff for their role and could be extended if required. Annual appraisals have been completed in the four of five staff files reviewed; one has been employed for less than a year.
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	PA Moderate	Registered nurses (RN) are responsible for conducting all assessments and for the development of care plans. Five resident files were reviewed, including one resident under Accident Compensation Corporation (ACC) funding. There was evidence of family/whānau involvement in the interRAI assessments and long-term care plans reviews. Specific cultural assessments are completed for all residents, and values, beliefs, and spiritual needs are documented in the care plan. Millvale House Miramar uses a range of risk assessments alongside the interRAI care plan process. Risk assessments conducted on admission

and whānau to support wellbeing.		include (but not limited to) those relating to falls; pressure injury; behaviour; continence; nutrition; skin; culture; activities; and pain. The initial assessments and care plans have not always been completed within 24 hours of admission. For the resident files reviewed, the outcomes of the assessments formulate the basis of the long-term care plan. The individualised long-term care plans (LTCPs) are developed with information gathered during the initial assessments and the interRAI assessment. All long-term care plans and interRAI assessments sampled had been completed within three weeks of the residents' admission to the facility. InterRAI assessments and reassessments have been completed within expected timeframes for all residents including the one resident on ACC funding. Documented interventions did not always meet the residents' assessed needs. All residents have a behaviour assessment and a behaviour plan, which included triggers of behaviours with associated risks documented but did not always include detailed behaviour interventions to guide staff in the delivery of care. The previous audit shortfall related to criteria # 3.2.3 has not been fully addressed. The care plans include a 24-hour reflection of close to normal routine for the resident. Short-term care plans are developed for acute problems, for example infections, wounds, and weight loss and are signed off when resolved or moved to the long-term care plans. Resident care is evaluated on each shift and reported at handover and in the progress notes. Long-term care plans are formally evaluated by a registered nurse; where progress was different from the expected goals as documented in the care plan evaluation, there was no evidence of updates to the care plan. Not all care plan evaluations have not been completed at the same time as the resident's interRAI re-assessment, care plan review/ and multidisciplinary meeting (MDT). Family/whanau interviewed confirmed resident assessments are completed according to their needs and in the privacy of their bedrooms. There was evidence of family/whānau involvement in the care planning and review process. Family/whanau stated they were notified of all changes to health, including infections, accident/incidents, general practitioner visits and medication changes and this was consistently documented in the resident files. When a resident's condition changes, the staff alert the registered nurses, who then assesses the resident and initiate a review with the general practitioner. The service has policies and procedures in place to support all

		residents to access services. The service supports and advocates for residents with disabilities to access relevant disability services. A physiotherapist visits the facility weekly and on request, to review residents referred by the registered nurses. There is access to a continence specialist as required. A podiatrist visits regularly and a dietitian, speech language therapist, mental health services for older people (OPMH), palliative care nurse and medical specialists are available as required through Health New Zealand. The general practitioner (GP) from local medical centre provides weekly medical services, including after hours on-call support. Residents are reviewed by the general practitioner on admission, acutely, or for a monthly / three-monthly review. There is evidence in the resident files that the residents were seen by the GP within five working days of admission, and resident regular reviews occurred as per required timeframes. More frequent medical reviews were evidenced in files of residents with more complex conditions or acute changes to health status. Interview with the general practitioner (who has recently started in the last two months) confirmed that staff demonstrated good clinical assessments and follow-up with any plans of care. Caregivers and registered nurses interviewed could describe a verbal and written handover at the beginning of each shift that maintains a continuity of service delivery which they found to be comprehensive and informative. Progress notes are written on every shift by the caregivers and the registered nurses document at least daily and as necessary in the resident records. An adequate supply of wound care products was available at the facility. A review of the wound care plans evidenced that wounds were assessed promptly and reviewed at appropriate intervals. Photos were taken when this was required. Where wounds required additional specialist input, this was initiated, and the wound care nurse specialist was consulted. At the time of the audit there were nine active wounds from seven residents which included skin tears, abrasions, lesions and one unstageable pressure injury which was evidencing good progress towards healing. Monthly observations such as weight and blood pressure were completed and are current. Neurological observations are recorded following un-witnessed falls or where head injury is suspected. A range of monitoring charts are available for the care staff to utilise. These include (but not limited

		to) monthly blood pressure; weight monitoring; behaviour; bowel records; blood glucose levels, food intake charts and fluid balance monitoring. Monitoring charts have been completed as per care plan instructions. Staff interviews confirmed they are familiar with the needs of all residents in the facility and that they have access to the supplies and products they require to meet those needs. Staff receive handover at the beginning of their shift, as observed on the day of audit.
Subsection 3.4: My medication The people: I receive my medication and blood products in a safe and timely manner. Te Tiriti: Service providers shall support and advocate for Māori to access appropriate medication and blood products. As service providers: We ensure people receive their medication and blood products in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	Millvale House Miramar has policies available for safe medicine management that meet legislative requirements. The registered nurses and medication competent caregivers who administer medications, are assessed annually for competency. Not all staff that required a competency had a current competency on file (link 2.3.3). Education around safe medication administration is provided. All medication charts and signing sheets are electronic. On the day of the audit, a registered nurse was observed to be safely administering medications. The registered nurse and caregivers interviewed could describe their roles regarding medication administration. Millvale House Miramar uses robotic rolls for all regular, short course and 'as required' medicines. All medications once delivered are checked by the registered nurses against the medication chart. Any discrepancies are fed back to the supplying pharmacy. Expired medications are returned to the pharmacy in a safe and timely manner. Medications were appropriately stored in the medication trolley and medication room. The medication fridge and medication room temperatures are monitored daily, and the temperatures were within acceptable ranges. All eyedrops have been dated on opening. Ten medication charts were reviewed. There is a three-monthly general practitioner review of all the residents' medication charts, and each drug chart has photo identification and allergy status identified. All 'as required' medications had prescribed indications for use. The effectiveness of 'as required' medication has been documented in the electronic medication system. The service does not use standing orders and there are no vaccines kept on site. Due to the nature of the service, there were no residents self-administering medications. There is documented evidence in the clinical files that family/whānau are

		updated about changes to the resident medications and health.
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	All meals are prepared and cooked on site. The kitchen was observed to be clean, well-organised, well equipped and with a current approved food control plan expiring 1 May 2025. The four-weekly seasonal menu has been reviewed by a dietitian. A resident dietary profile is developed for each resident on admission, and this is provided to the kitchen. The kitchen meets the needs of residents who require special diets. The cook works closely with the registered nurses with resident's dietary profiles and any allergies. The cook stated they accommodate any requests from residents within reason. Snacks are available 24/7 for residents. Family/whānau members interviewed indicated satisfaction with the food.
Subsection 3.6: Transition, transfer, and discharge The people: I work together with my service provider so they know what matters to me, and we can decide what best supports my wellbeing when I leave the service. Te Tiriti: Service providers advocate for Māori to ensure they and whānau receive the necessary support during their transition, transfer, and discharge. As service providers: We ensure the people using our service experience consistency and continuity when leaving our services. We work alongside each person and whānau to provide and coordinate a supported transition of care or support.	FA	There are documented policies and procedures to ensure discharging or transferring residents have a documented transition, transfer, or discharge plan, which includes current needs and risk mitigation. Planned discharges or transfers were coordinated in collaboration with the family/whānau and other service providers to ensure continuity of care.
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.	FA	The buildings, plant, and equipment are fit for purpose at Millvale House Miramar and comply with legislation relevant to the health and disability services being provided. The environment is inclusive of people's cultures and supports cultural practices. The current building warrant of fitness expires 29 June 2025. There is an electronic maintenance request process for repairs. Equipment

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.		failure or issues are also recorded in the maintenance electronic log. This is checked daily and signed off when repairs have been completed. There is an annual maintenance plan that includes electrical testing and tagging, equipment checks, call bell checks, calibration of medical equipment, and monthly testing of hot water temperatures. Hot water temperatures have been checked weekly and demonstrate that they have been within expected ranges. Essential contractors/tradespeople are available 24 hours a day as required.
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 infection prevention control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, and the training and education of staff. The infection control programme linked to the quality system. Infection control is included in the internal audit schedule. Any corrective actions identified have been implemented and signed off as resolved. The infection control programme is reviewed and reported on six monthly. The infection control policy states that Millvale House Miramar is committed to the ongoing education of staff and residents. Infection prevention and control is part of staff orientation and included in the annual training plan; however, not all staff have attended and completed the required training (link 2.3.4). The infection control coordinator has undertaken recent education online (completed February 2025) and has additional support from expertise at Health New Zealand.
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,	FA	The infection prevention control policy describes surveillance as an integral part of the infection prevention control programme. Monthly infection data is collected for all infections based on signs, symptoms, and the definition of the infection. Infections are entered into the electronic infection register and surveillance of all infections (including organisms) is collated onto a monthly infection summary. Reports include antibiotic use. This data is monitored and analysed for trends, monthly and annually. Millvale House Miramar incorporates ethnicity data into surveillance methods and data captured around infections.

priorities, and methods specified in the infection prevention programme, and with an equity focus.		Infection control surveillance results are discussed at infection control, and quality meetings. Meeting minutes and data are available for staff. Action plans are completed for any infection rates of concern. Millvale House Miramar receives regular notifications and alerts from Health New Zealand for any community concerns. There have been two Covid-19 outbreaks since last audit; in December 2023 and October 2024. These were documented, well managed and reported.
Subsection 6.1: A process of restraint The people: I trust the service provider is committed to improving policies, systems, and processes to ensure I am free from restrictions. Te Tiriti: Service providers work in partnership with Māori to ensure services are mana enhancing and use least restrictive practices. As service providers: We demonstrate the rationale for the use of restraint in the context of aiming for elimination.	FA	Maintaining a restraint-free environment is the aim of the service. This is supported by the governing body. Restraint use is discussed and monitored at the organisational six-monthly restraint approval group meeting (last held 6 March 2025) and registered nurse and quality meetings. At the time of the audit, there were no residents using restraints. The designated restraint coordinator is a registered nurse. Staff attend training in challenging behaviours, including de-escalation techniques (last held in February 2025) and restraint use last held in March 2025 .

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 1.8.3 My complaint shall be addressed and resolved in accordance with the Code of Health and Disability Services Consumers’ Rights.	PA Low	The clinical manager maintains complaints register which includes all complaints, dates and actions taken. The has been three internal complaints received since last audit in August 2023. Documentation including acknowledgement, follow-up letters and resolution were completed. However, for one of the complaints logged on 14 May 2024, the outcome and resolution was only sent to the complainant post the 20 working days with no documented communication to the complainant regarding the delay in the process.	Timeframes for complaints resolution have not been followed to ensure ongoing communication and resolution within 20 working days for complaints reviewed.	Ensure that all complaints are managed in accordance with guidelines set by HDC. 90 days
Criterion 2.2.6 Service providers shall understand and comply with	PA Low	Interview with the clinical manager evidenced awareness of the service’s requirement to notify relevant authorities	Staff did not complete a section 31 notifications as per policy.	Ensure that the required notification under section 31 is completed as per

statutory and regulatory obligations in relation to essential notification reporting.		in relation to essential notifications. There have been section 31 and Severity Assessment Code (SAC) notifications to Health Quality and Safety Commissioner (HQSC) reported related to resident absconding, pressure injuries and change in clinical manager. There are systems and processes are in place to ensure roster management contractual requirements are met and mandatory reporting is completed. However, not all roster management processes have been completed by onsite staff as required. Processes that deviated from those required by the organisation included substituting RNs for L4 HCAs, failing to report roster changes and the requirement for Section 31 reporting. Review of the staff roster for the period of January and February 2025 identified five shifts did not have 24/7 registered nurse cover. The risks were mitigated by replacing the RN shift with a level 4 caregiver (with the clinical manager being on call). There is no evidence of the required reporting to HealthCERT.		policy. 90 days
Criterion 2.3.1 Service providers shall ensure there are sufficient health care and support workers on duty at all times to provide culturally and clinically safe services.	PA Moderate	There are systems and processes in place to manage planned and unplanned staff leave to meet contractual requirements; however, not all staff have completed processes required when rosters were changes between 3 and 21 March 2025. Over the last six months the service has	Not all staff followed the systems and processes in place when rosters were changes.	Ensure all policies and procedures are followed when there are changes to the roster. 60 days

		employed additional registered nurses to ensure a full complement of registered nurses at 5FTE level. One registered nurse commenced employment in October 2024 and the last one commenced employment on 10 March 2025. Although the service has a full complement of registered nurses, processes undertaken to notify the regional manager was not completed as per policy resulting in shifts being covered by a level 4 caregiver with the clinical manager on call for support. Review of the staff roster for the period of January and February 2025 identified five shifts did not have 24/7 registered nurse cover. Review of the March 2025 roster confirms that there was one non-clinical staff member who worked continuously from 3 March to 21 March (8-hour days) without a day off. This was identified as one off incident where the cook went on holiday, after the roster had been printed. The kitchen staff covered the absence in the short term and did not alert the operations manager of the changes as per policy.		
Criterion 2.3.3 Service providers shall implement systems to determine and develop the competencies of health care and support workers to meet the needs of people	PA Moderate	All staff are required to complete competency assessments as part of their orientation and annually. Review of the training records confirm that only six staff had completed moving and handling competency in March 2024 and five in April 2025. The main level four caregiver who was filling in for the registered nurse	Staff have not completed all the required annual competencies as per the DCNZ education and training schedule.	Ensure that all staff have completed the required competencies to meet the needs of the residents. 60 days

equitably.		shifts at any time that the service did not have a registered nurse, did not have a current medication competency. All registered nurses have current medication competencies.		
Criterion 2.3.4 Service providers shall ensure there is a system to identify, plan, facilitate, and record ongoing learning and development for health care and support workers so that they can provide high-quality safe services.	PA Low	There is an annual education and training schedule being implemented for 2025. The education and training schedule lists compulsory training, which includes cultural awareness training and topics related to caring for the older person. Review of the training records confirm that all the mandatory training scheduled for 2024 was delivered; however, there was very low attendance numbers documented of the required training in 2024. Training documentation reviewed evidenced compliance of less than 40% of total staff expected to attend. The service maintains an attendance register electronically and in the staff personnel file. Training is delivered as in-services, competency questionnaires, online learning, and external professional development.	Mandatory training has been completed as scheduled since the last audit; however, there has been low numbers of staff attending or completing the required mandatory training in 2024.	Ensure all staff attend and complete the required mandatory training. 90 days
Criterion 3.2.1 Service providers shall engage with people receiving services to assess and develop their individual care or support plan in a timely manner. Whānau shall be	PA Low	All initial assessments and care plans are completed by a registered nurse on admission. The policy provides guidance to ensure that an initial care plan is developed within 24 hours of admission with detailed information to guide caregivers on care delivery for the	Two resident files reviewed did not have initial assessments and care plans completed within the required timeframe.	Ensure that initial care plans and assessments are completed within the required timeframes 90 days

involved when the person receiving services requests this.		residents. Two of five files reviewed did not have initial assessments and care plans completed within the required time frame. For one resident they had initial assessments completed within 24 hours, but the initial care plan was completed after four weeks. The other resident had initial assessments completed 48 hours after admission and the initial care plan was completed on day 7 of admission.		
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	PA Moderate	The registered nurses are responsible for the development of the care plan. Assessment tools, including cultural assessments, were completed to identify key risk areas. Alerts are indicated on the resident care plan and include (but not limited to) high falls risk, weight loss, wandering, and pressure injury risks. The registered nurses interviewed understand their responsibility in relation to assessment and care planning. There are comprehensive policies in place related to assessment and care planning; however, care plan interventions did not always reflect the current needs of the resident. Caregivers are knowledgeable about the care needs of the residents and the family/whānau interviewed were complimentary of the care provided. Progress notes and monitoring records evidence care delivery to the residents, reflective of their needs, as described by staff during interviews and confirmed by family/whānau interviewed. The findings related to care planning relates to	(i).Initial care plan for a recent admission did not provide detailed interventions to guide staff in the delivery of care in relation to a choking risk and behaviour management. (ii). One resident with aggressive behaviour did not have detailed interventions documented to guide staff in the delivery of care. The care plan for the same resident continued to mention that the resident was wandering yet they have been bed and chair bound since October 2024.	(i)-(ii).Ensure that care plan documentation reflects the residents' current needs and that interventions documented provide detailed information to guide staff in the delivery of care for the residents. 90 days

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 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.		documentation only.		
Criterion 3.2.5 Planned review of a person's care or support plan shall: (a) Be undertaken at defined intervals in collaboration with the person and whānau, together with wider service providers; (b) Include the use of a range of outcome measurements; (c) Record the degree of achievement against the person's agreed goals and aspiration as well as whānau goals and aspirations; (d) Identify changes to the person's care or support plan, which are agreed collaboratively through the ongoing re-assessment and review process, and ensure	PA Low	Long-term care plans are formally evaluated by a registered nurse every six months and include the degree of achievement towards meeting desired goals and outcomes. The multi-disciplinary team review meetings provide evidence of collaboration with family/whanau. The regional clinical manager visits facilities frequently at regular intervals and assists RNs in the review of care plans. At the time of audit, three of three care plan evaluations for residents who had been in the facility for more than six months had care plan evaluations completed the regional clinical manager in collaboration with the clinical manager. The care plan evaluations were not evidenced as being completed at the same time as the interRAI assessments, care plan review and MDT process. Where the progress	(i).Three of three care plan evaluations have not been completed at the same time as the resident's interRAI re-assessment, care plan review and MDT. (ii).Where progress was different from the expected goals as documented in the care plan evaluation, there was no evidence of updates to the care plan.	(i).Ensure care plan evaluations are completed at the same time as the resident's interRAI re-assessment, care plan review and MDT. (ii).Ensure the care plan is updated, where progress is different from the expected outcome. 90 days

changes are implemented; (e) Ensure that, where progress is different from expected, the service provider in collaboration with the person receiving services and whānau responds by initiating changes to the care or support plan.		was documented in the care plan evaluation as different from the expected outcome, there was no evidence of updates to the care plan.		

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.