Carter Society Incorporated - Carter Court Rest Home

Introduction

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

The audit has been conducted by The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to 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:	Carter Society Incorporated
Premises audited:	Carter Court Rest Home
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 16 April 2025 End date: 17 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: 40

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

Carter Court Rest Home is currently certified to provide rest home and hospital level care for up to 43 residents. The facility is owned by the Carter Society Incorporated and is managed by a facility manager who is experienced in the sector, supported by a nurse manager who is a registered nurse. Residents and whānau stated the care provided was of a high standard.

This certification audit process included review of policies and procedures, review of resident and staff files, observations, and interviews with residents, whānau, members of the governance group, managers, staff, and a general practitioner(s).

Improvements are required in the areas of completion of neurological observations following unwitnessed falls, and in the attendance and recording of the training programme.

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.		Subsections applicable to this service fully attained.

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

There were processes in place to ensure that Pacific peoples are provided with services that recognise their worldviews and are culturally safe.

Residents and their whānau were informed of their rights according to the Code of Health and Disability Services Consumers' Rights (the Code) and these were upheld. Personal identity, independence, privacy and dignity were respected and supported. Staff have participated in Te Tiriti o Waitangi training, which was reflected in day-to-day service delivery. Residents were safe from abuse.

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

Complaints were resolved promptly and effectively in collaboration with all parties involved.

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

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

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

The National Adverse Events Policy was followed, with corrective actions supporting systems learnings. The service complied with statutory and regulatory reporting obligations.

An optimised workforce composition met the cultural and clinical needs of residents. Staff were appointed, orientated and managed using current good practice. A systematic approach to identify ongoing learning supported safe equitable service delivery.

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

Ngā huarahi ki te oranga | Pathways to wellbeing

Includes eight subsections that support an outcome where people participate in the development of their pathway to wellbeing, and receive timely assessment, followed by services that are planned, coordinated, and delivered in a manner that is tailored to their needs.		Subsections applicable to this service fully attained.

When people entered the service, a person-centred and whānau-centred approach was adopted. Relevant information was provided to the potential resident and whānau.

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

Residents were 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 safely managed and administered by staff who were 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 were 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 fully attained.

The facility met the needs of residents and was clean and well maintained. There was a current building warrant of fitness. Biomedical and electrical equipment was tested as required. Internal and external areas are accessible and safe; external areas have shade and seating provided and meet the needs of tāngata whaikaha (people with disabilities).

Staff have planned and implemented strategies for emergency management. They are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Staff, residents and whānau understood emergency and security arrangements. Residents and their whānau 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 fully attained.

The governing body ensured the safety of residents and staff through planned infection prevention and antimicrobial stewardship programmes that were appropriate to the size and complexity of the service. An experienced and trained infection control coordinator led the programme.

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

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

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

The environment supported both preventing infections and mitigating their transmission. Waste and hazardous substances were managed well. There were safe and effective cleaning and 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.		Subsections applicable to this service fully attained.

The service is a restraint-free environment. This is supported by the governing body and policies and procedures. There were no residents using restraints at the time of audit.

Carter Court Rest Home had documentation in place to manage restraint, including for restraint assessment, approval, consent, monitoring and review. Policy requires that restraint be used only as a last resort and when all other interventions/strategies have failed.

The restraint coordinator was an enrolled nurse who had a defined role to provide support and oversight for restraint management should this be required. Staff interviewed demonstrated knowledge of restraint processes, including least restrictive practice, de-escalation techniques, alternative interventions, and restraint monitoring.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Subsection	0	25	0	1	1	0	0
Criteria	0	167	0	1	1	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	Carter Court Rest Home (Carter Court) has a Māori health policy and plan in place, which describes how the organisation responds to the cultural needs of Māori residents and how it fulfils its obligations and responsibilities under Te Tiriti o Waitangi. The policy and plan address tino rangatiratanga, equity, partnership, Te Whare Tapa Whā model of health, tikanga, and use of te reo Māori in its facilities. The Māori Health Plan has been developed with input from cultural advisers, and this can be used at Carter Court for residents who identify as Māori. Residents participated by providing input into their care planning, activities, and dietary needs. Care plans included the physical, spiritual, whānau, and psychological health of the residents. There were Māori residents present in the facility during the audit. Māori residents and their whānau interviewed reported that they were comfortable at the facility and expressed feelings and experiences that were consistent with cultural safety, confirming that mana motuhake (self-determination) was respected. The service supported increasing capacity for Māori within the service by employing more Māori staff members across differing levels of the organisation as vacancies and applications for employment permitted. Ethnicity data was gathered when staff were employed, and this data

		was analysed at a management and organisational level. There were staff who identified as Māori employed by the service at the time of audit. The service has links for Māori health support through local kaumātua, through its links to local marae, and Māori community organisations. There was access to rongoā Māori through a local practitioner.
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	Carter Court has identified and works in partnership with Pacific communities and organisations. There were no residents who aligned with a Pacific community in the service on the days of audit; however, there is a Pacific plan in place to allow the service to support equitable and culturally safe care for Pacific peoples using the service. Partnerships with local Pacific communities enables ongoing planning and evaluation of services and outcomes. The Fonofale model of care guides care for Pacific peoples. Active recruitment, training and actions to retain a Pacific workforce are supported through policy. Ethnicity data was gathered when staff were employed, and this data was analysed at a management and organisational level. There were staff who identified with a Pacific community employed at the time of audit.
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	Carter Court was aware of its responsibilities under the Code of Health and Disability Services Consumers' Rights (the Code) and has policies and procedures in place to ensure these are respected. Staff interviewed from both the am and pm shifts understood the requirements of the Code, including the right to self-determination (mana motuhake), and were observed supporting residents in accordance with their wishes. The Code was displayed at the main entrance reception and at points throughout the facility. Intending residents were provided with a copy of the Code and the Carter Society Incorporated 'residents' rights and responsibilities' document, with their admission information. The Health and Disability Commissioner Code of Rights – Māori Ōu Motika and the Nationwide Health and Disability Advocacy Service – Ngā Kaitautoko

		brochures are readily available for residents, whānau and staff. Residents and whānau interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) and were provided with opportunities to discuss and clarify their rights.
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	Carter Court 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. Church services were held weekly and were seen to be well attended, and several residents received communion on Sundays. The church minister and pastoral carer interviewed confirmed they actively supported residents spiritually at the weekly service, and as required for pastoral care conversations and prayer. Staff routinely contacted the minister to bless the room and provide prayer following the death of a resident. Staff were observed to maintain privacy throughout the audit. All residents have a private room with ensuite or access to a communal bathroom. Te reo Māori and tikanga Māori were promoted within the service through policy and education of staff and activities of residents. Key resident information, such as the Code of Rights, was displayed in te reo Māori. Tikanga guidelines were displayed in the staff room and facility manager's (FM) office. Staff had undertaken training in Te Tiriti o Waitangi and understood the principles and how to apply these in their daily work. Te Tiriti o Waitangi was included in the paid compulsory annual study day. The needs of tāngata whaikaha were 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	Carter Court 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, resident, whānau and Enduring Power of Attorney (EPOA) interviews, or in documentation reviewed. Residents' property was labelled on admission; a resident, whānau and EPOA interviewed reported that residents' property was respected and well cared for. Resident finances were protected. Professional boundaries were maintained by staff. Staff interviewed felt comfortable in raising any concerns in relation to institutional and systemic racism and that any concerns would be acted upon. Care provision was holistic, encompassing the pillars of Te Whare Tapa Whā, and was based on the identified strengths of residents. Wellbeing outcomes for all residents, including Māori, was evaluated as part of the assessment and care planning process six-monthly to ensure the needs of residents were met.
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.	FA	Residents and whānau reported that communication was open and effective, they had opportunities to discuss their needs and felt listened to. Information was provided in an easy-to-understand format, and staff described steps taken to ensure good communication for residents with communication difficulties. Staff training was included in the induction programme. Changes to residents' health status were communicated to whānau in a timely manner. The general practitioner (GP) interviewed stated communication from staff was appropriate and timely and included all relevant information. Examples of open communication were evident following adverse events and during management of any complaints. 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	FA	Residents and their legal representative were provided with the information necessary to make informed decisions. With the consent of

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.		the resident, whānau were included in decision-making. The resident, whānau and EPOA interviewed felt empowered to actively participate in decision-making. Nursing and care staff interviewed understood the principles and practice of informed consent and described involving residents and whānau in the process. Tikanga guidelines were available to support staff when working with Māori residents and whānau; these were known to staff. Advance care planning, establishing and documenting of EPOA requirements and processes for residents unable to consent were documented, as relevant, in the resident's record. All residents' files sampled had a documented EPOA on file and if required they had been activated by an appropriate medical practitioner; staff were aware and understood who to contact.
Subsection 1.8: I have the right to complain The people: I feel it is easy to make a complaint. When I complain I am taken seriously and receive a timely response. Te Tiriti: Māori and whānau are at the centre of the health and disability system, as active partners in improving the system and their care and support. As service providers: We have a fair, transparent, and equitable system in place to easily receive and resolve or escalate complaints in a manner that leads to quality improvement.	FA	A fair, transparent and equitable system was in place to receive and resolve complaints that led to improvements. This met the requirements of the Code. Information on complaints and the complaints process was available in English and te reo Māori. Residents and whānau interviewed understood their right to make a complaint and knew how to do so. There have been three complaints received by the service in the last 12 months. All complaints, formal and informal, were managed as per the Carter Court complaints process. Documentation sighted in respect of the complaints showed that all complaints had been responded to within appropriate timeframes and that the complainants had been informed of findings and any corrective action arising from the complaint following investigation. There have been no complaints from Māori in the service, but there were processes in place to ensure complaints from Māori are managed in a culturally appropriate way (eg, using culturally appropriate support, hui, and tikanga practices specific to the resident or the complainant). There have been no complaints received from external sources since the previous (surveillance) audit.

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 Carter Court governing body assumes accountability for delivering a high-quality service through supporting meaningful inclusion of Māori and Pacific peoples in governance. Carter Court utilises its Māori and Pacific connections to assist it in meeting its obligations to Māori and Pacific peoples in its organisation, honouring Te Tiriti o Waitangi and actively promoting improved outcomes for Māori, Pacific peoples and tāngata whaikaha (people with disabilities). Board members had completed cultural training and have taken opportunities to upskill in Te Tiriti o Waitangi and health equity via education, and through other community roles and/or employment. Compliance with legislative, contractual and regulatory requirements was overseen by the leadership team and governance group, with external advice sought as required. Information garnered from these sources translated into policy and procedure. Equity for Māori, people who identify as from a Pacific community, and tāngata whaikaha was addressed through the policy documentation and enabled through choice and control over supports and the removal of barriers that prevent access to information (eg, information in other languages for the Code, complaints and infection prevention and control, and bilingual signage). Specific models of care relevant to Māori and Pacific communities were available for use in the provision of culturally appropriate care. The needs of tāngata whaikaha were specifically addressed in an ‘Enabling Independence’ policy. 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, and with staff. Carter Court has a strategic plan in place that outlines the organisation’s structure, purpose, values, scope, direction, performance and goals. The plan supports the improvement of equitable outcomes for Māori, Pacific peoples and tāngata whaikaha. The reporting structure at Carter Court relied on information from its strategic plan to inform its annual plan. Cultural safety was embedded in strategic, business and quality plans and in staff orientation and training. Ethnicity data was being collected and analysed for residents and staff to support

		equity. Governance and the management team were committed to quality and risk via policy, processes, and through feedback mechanisms. Members of the governance group interviewed felt well informed on progress and risks. The clinical governance group was appropriate to the size and complexity of the organisation. Internal data collection (eg, adverse events, infection control, complaints, and any restraint use) were aggregated and corrective actions carried out; outcomes from these activities were reported to the Board. Changes were made to business and/or the strategic plans as required. The FM at Carter Court has aged-care experience; they have been with the service for four years. The FM is supported clinically by a nurse manager (NM), who is an experienced registered nurse (RN) and has clinical oversight of the facility. The FM and NM confirmed knowledge of the sector, regulatory and reporting requirements and both maintain currency within the field. Carter Court supported residents and their whānau to participate in the service through ongoing communication, care and support planning, resident meetings, and an annual resident satisfaction survey. Responses from meetings and surveys, and through interviews with residents and their whānau during the audit, were noted to be very positive. The service holds contracts with Te Whatu Ora – Health New Zealand (Te Whatu Ora) under age-related residential care (ARRC) contracts for rest home and hospital services, short-term care (respite), long-term support- chronic health conditions (LTS-CHC) and has a fully funded health recovery bed. The service also has a contract to provide services under the Accident Compensation Corporation (ACC). On the day of audit, 40 residents were receiving services: 25 rest home services (including one funded under an ACC contract), and 15 hospital level services (including one under the LTS-CHC contract, and one utilising the health recovery bed). There were no residents receiving respite services.

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	The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This was included in the strategic and annual plans, policy documentation, and the quality management framework in place (which includes health and safety risks and management). Progress against quality outcomes was evaluated, and relevant corrective actions were developed and implemented to address any shortfalls. Quality data was communicated and discussed throughout the organisation, and this was confirmed by records sighted and by governance representatives and staff at interview. Policies reviewed covered all necessary aspects of the service and contractual requirements, and these were current. Documentation is the responsibility of the FM in consultation with the governance and clinical team, and community organisations as applicable (including for Māori and Pacific peoples). Critical analysis of organisational practices to improve health equity was occurring across the organisation, with appropriate follow-up and reporting. A Māori health plan guides care for Māori. The FM and NM described the processes for the identification, documentation, monitoring, review and reporting of risks, including health and safety risks, and development of mitigation strategies. Where mitigation strategies were identified, there were processes in place to ensure these were corrected. Staff documented adverse and near miss events in line with the National Adverse Events Reporting Policy. A sample of adverse events forms reviewed showed these were fully completed, incidents were investigated, and action plans developed. Most actions arising from adverse events were followed up in a timely manner; the exception to this was the completion of neurological observations following unwitnessed falls (refer criterion 2.2.4). The FM and NM understood and have complied with essential notification reporting requirements. In the last 12 months, there has been one Section 31 notification made to HealthCert at Manatū Hauora – Ministry of Health related to a medication error, and two notifications to Te Tāhū Hauora - Health Safety & Quality Commission (HSQC) related to falls with a fracture.

Subsection 2.3: Service management The people: Skilled, caring health care and support workers listen to me, provide personalised care, and treat me as a whole person. Te Tiriti: The delivery of high-quality health care that is culturally responsive to the needs and aspirations of Māori is achieved through the use of health equity and quality improvement tools. As service providers: We ensure our day-to-day operation is managed to deliver effective person-centred and whānau-centred services.	PA Low	There is a documented and implemented process for determining staffing levels and skill mixes to provide culturally and clinically safe care, 24 hours a day, seven days a week (24/7). The facility adjusted staffing levels to meet the changing needs of residents, and staff confirmed that they had adequate time to complete the work allocated to them. A multidisciplinary team (MDT) approach ensured all aspects of service delivery were met. Residents and whānau interviewed supported this. At least one staff member on duty had a current first aid certificate and there is 24/7 RN coverage in the hospital. Position descriptions reflected the role of the position and expected behaviours and values. Descriptions of roles cover responsibilities and additional functions, such as holding an infection control (IC), or restraint portfolio. Continuing education was identified and planned on a biennial basis (over two years) and the programme included mandatory training requirements. Records reviewed showed that there is no integrated process for recording education delivered; some of the education delivered was attended by low numbers of staff, and some staff did not attend education at all in 2024 (refer criterion 2.3.4). Competencies were assessed and supported equitable service delivery. Staff have access to the New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with Te Whatu Ora. Participation from the residents using the service, and their whānau, was direct through the open-door policy of managers, and through planned activities such as meetings, satisfaction surveys and the feedback processes. High-quality Māori health information was accessed and used to support the training programme, policy development, and care delivery. Staff reported feeling well supported and safe in the workplace. There are policies and procedures in place around wellness, bullying and harassment. An employee assistance programme (EAP) was available to staff who may require extra support.

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	Human resources management policies and processes are based on good employment practice and relevant legislation. A sample of staff records reviewed (eight) confirmed the organisation's policies were being consistently implemented. Police vetting and reference checking were in place. Job descriptions were documented for each role, including for infection prevention and control and restraint. The job descriptions described the skills and knowledge required of each position, and identified the outcomes, accountability, responsibilities, authority, and functions to be achieved. Professional qualifications and registration (where applicable) had been validated prior to employment, and these are then checked annually. Staff reported that the induction and orientation programme prepared them well for the role, and evidence of this was seen in files reviewed. Staff interviewed confirmed that orientation does take place and described it as useful in preparing them for their role. Opportunities to discuss and review performance occur three months following appointment and yearly thereafter, as confirmed in records reviewed. Staff performance was reviewed and discussed at regular intervals. Staff confirmed that they have input into the performance appraisal process. Staff confirmed that debrief and support was available to them following any incidents. Information held about staff was accurate, relevant, secure, stored, and archived confidentially. Electronic data was username and password protected. Information is available only to those authorised to use it. Ethnicity data was being recorded for staff and used in accordance with 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	FA	Carter Court maintained records that complied with relevant legislation, health information standards and professional guidelines. Most resident and staff information were paper-based, and records were held securely and only available to authorised users. Any information that was electronic was username and password protected. Access was limited dependent on the role of the person in the service. Files were archived

of personal and health information of people using our services is accurate, sufficient, secure, accessible, and confidential.		securely for the required period before being destroyed. No personal or private information was on public display during the audit. Demographic, personal and health information was completed in the residents' files sampled for review. Data collected included ethnicity data for residents and staff. Clinical notes were current, integrated and legible. Consent was sighted for data collection. Carter Court is not responsible for National Health Index registration.
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 enter the service based on documented entry criteria available to the community and understood by staff. Residents enter the service when their required level of care had been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) agency. Files reviewed met contractual requirements. Residents were welcomed into the service when assessment by the local NASC confirmed they required the level of care offered at Carter Court. Residents were provided with a comprehensive admission pack including residential care agreement, code of rights and advocacy, financial information and information regarding Carter Court and the Carter Society Incorporated. Residents and whānau interviewed were satisfied with the admission process and the information that had been made available to them on admission. Enquiries were documented and, where a prospective resident was declined entry, there were processes for communicating the decision. Related data was documented and analysis of entry and decline rates, including for Māori, was occurring. Carter Court has developed partnerships with the local Māori marae and Māori advisers through the Carterton District Council and Health New Zealand. They supported Māori and their whānau when entering the service. There were currently no residents who had requested the services of a Māori health practitioner or traditional Māori healer, but this service was available.

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.	FA	The multidisciplinary team at Carter Court worked in partnership with the resident and whānau to support wellbeing. Resident files were paper based, with the exception of medication management. Care plans, based on the provider's model of care, were developed by the RNs and the diversional therapist (DT) following a comprehensive assessment, including consideration of the person's lived experience, needs, values, and beliefs, and which consider wider service integration, where required. Early warning signs and risks, with a focus on prevention or escalation for appropriate interventions, were recorded. Assessment was based on a comprehensive range of clinical assessments and included resident and whānau input (as applicable). Timeframes for the initial assessment, medical assessment, initial care plan, long-term care plan and review timeframes met contractual/policy requirements. Staff understood the needs of residents and whānau, including Māori, to identify their own pae ora outcomes in their care plan. This was verified by sampling residents' records, and from interviews with clinical staff, people receiving services and whānau. Management of any specific medical conditions was well documented, with evidence of systematic monitoring and regular evaluation of responses to planned care, including the use of a range of outcome measures. Where progress was different to that expected, changes were made to the care plan in collaboration with the resident and/or whānau. Residents and whānau confirmed active involvement in the process. Tāngata whaikaha participated in service development through assessments, including resident profile, recreation and lifestyle care plan. Examples of choices and control over service delivery were discussed with staff/tāngata whaikaha/whānau. Tāngata whaikaha/whānau can independently access information. Residents and whānau interviewed were all positive regarding the clinical care and support received, the communication, the food provided, and the activities offered. Interview with the GP confirmed communication with the clinical team

		was excellent. They visited Carter Court once a week to maintain medical services, and at other times they were available by telephone or text. If a resident's condition changed in the interim, clinical staff would complete an SBAR form and send directly to the medical centre. If unavailable, in an emergency or after hours, the staff would work with the medical centre, which had access to two other GPs. Medication changes were managed in real time through the electronic medicine management system.
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 supported residents in maintaining and developing their interests and was appropriate for their age and stage of life. A monthly calendar of activities was planned, and residents were guided by the monthly planner. A broad range of activities were offered including games, quizzes, entertainment, church services, outings, and celebrations. The DT was unavailable at the time of audit, but evidence of their contribution to the life of Carter Court was evident through files and photos around the facility. The recreation officer was interviewed and expressed how much they enjoyed working at Carter Court and how supportive the programme was for residents and whānau. Activity assessments and plans identify individual interests and consider the person's identity. These included the resident profile, activity assessment, care plan, progress notes, activity attendance logs, one-on-one activity logs, and review and evaluation by the DT. 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 are facilitated. Community initiatives met the needs of Māori. Feedback on the programme was provided through resident meetings facilitated by the resident advocate, and minutes were available to staff, residents and whānau. Those interviewed confirmed they found the programme met their needs and appreciated the commitment and energy of the diversional therapist and recreation team.

Subsection 3.4: My medication The people: I receive my medication and blood products in a safe and timely manner. Te Tiriti: Service providers shall support and advocate for Māori to access appropriate medication and blood products. As service providers: We ensure people receive their medication and blood products in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	The medication management policy was current and in line with the Medicines Care Guide for Residential Aged Care/current best practice. A safe system for medicine management (using an electronic system) was observed on the day of audit. All staff who administer medicines were competent to perform the function they managed. Medication reconciliation occurred. 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. The required three-monthly GP review was consistently recorded on the medicine chart. Limited standing orders were used and complied with legislation. Self-administration of medication was facilitated for respite and health recovery residents and managed safely. Residents, including Māori residents and their whānau, were supported to understand their medications.
Subsection 3.5: Nutrition to support wellbeing The people: Service providers meet my nutritional needs and consider my food preferences. Te Tiriti: Menu development respects and supports cultural beliefs, values, and protocols around food and access to traditional foods. As service providers: We ensure people's nutrition and hydration needs are met to promote and maintain their health and wellbeing.	FA	The food service was in line with recognised nutritional guidelines for people using the services. The menu was reviewed by a qualified dietitian on 21 August 2024. Recommendations made at that time had been implemented. There were no corrective actions. All aspects of food management complied with current legislation and guidelines. The service operated with an approved food safety plan and registration. The food control plan was closed out on 14 May 2025 for review in 18 months. There were no corrective actions. Each resident had a nutritional assessment on admission to the facility. Personal food preferences, any special diets and modified texture requirements were accommodated in the daily meal plan. Staff followed

		the Australian standard for texture modified food and fluids. Māori and their whānau had menu options that were culturally specific to te ao Māori if required. Evidence of resident satisfaction with meals was verified by residents and whānau interviews 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. The kitchen team leader interviewed was a representative on the health and safety committee.
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 from the service was planned and managed safely with coordination between services and in collaboration with the resident and whānau. Risks and current support needs were identified and managed. Options to access other health and disability services and social/cultural supports are discussed, where appropriate. ISBAR, the brown envelope with yellow label system and the Carter Courts transfer form were used to guide staff to ensure vital information accompanied the resident during the transfer. Whānau reported being kept well informed during the transfer of their relative. A spreadsheet of all transfers/discharges/declines was maintained, including ethnicity. Evidence of actions taken to transfer residents to more appropriate facilities when their needs changed, such as dementia-level care, was sighted. Discharge from the health recovery programme involved a home visit and referral back to NASC for any home and community services they might need. Liaison with the nurse practitioners (NPs) or GPs would occur for residents if there were concerns prior to transfer or discharge.
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	FA	Appropriate systems were in place to ensure the residents' physical environment and facilities (internal and external) are fit for their purpose, maintained, and that they meet legislative requirements. There are areas external to the facility for leisure activities which are accessible

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.		and have 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 met the needs of residents, and these were also used for activities. Wi-Fi was available for residents and whānau to use, and access to equipment needed by tāngata whaikaha enabled. Space is available for the storage and charging of electronic mobility aids. 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. A combination of radiator panel heating, ceiling ducts and heat pumps are used for heating. Residents and whānau interviewed were satisfied the care home is kept appropriately warm, cooled, and ventilated. The temperature of the heating was adjusted by staff as required. 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 was part of the internal audit schedule. The building has a building warrant of fitness that expires on 30 June 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 and these were sighted. It was noted that there had been fluctuations in the water temperatures, and these were documented to have been addressed. Residents and whānau were happy with the environment, including heating and ventilation, natural light, privacy and maintenance. Care staff interviewed stated they had adequate equipment to safely deliver care for residents.

		No new buildings were planned at the current time; should this change in the future, the board and management at Carter Court were aware of the need to consult and co-design with Māori to reflect the aspirations and identity of Māori.
Subsection 4.2: Security of people and workforce The people: I trust that if there is an emergency, my service provider will ensure I am safe. Te Tiriti: Service providers provide quality information on emergency and security arrangements to Māori and whānau. As service providers: We deliver care and support in a planned and safe way, including during an emergency or unexpected event.	FA	The fire evacuation plan was approved by Fire and Emergency New Zealand (FENZ) on 3 September 2024. The requirements of the fire and emergency scheme were reflected in the facility's fire and emergency management plan. A trial evacuation has taken place six-monthly, with a copy sent to FENZ. Most staff had completed fire and emergency competency in 2024 (refer criterion 2.3.4); staff interviewed were able to describe what they should do in an emergency. Registered and enrolled nurses had completed fire warden education. Disaster and civil defence plans and policies direct the facility in its preparation for disasters and described the procedures to be followed. Staff had received relevant information and training and had appropriate equipment to respond to emergency and security situations. Adequate supplies for use in the event of a civil defence emergency met The National Emergency Management Agency recommendations for the region; alternative essential energy, food, water, and utility sources were available in the event of the main supplies failing, the kitchen has a hob that utilises 'tank' gas, and there were barbeques available to supplement cooking facilities. Information on emergency and security arrangements was provided to residents and their whānau on entry to the service. Carter Court staff had 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 responded promptly to call bells, and this was observed during the audit. Appropriate security arrangements were in place. The facility had overnight 'lock-up' procedures which allowed for emergency egress, and the front door has a doorbell to summon assistance. Residents and whānau were familiarised with emergency and security arrangements through a 'welcome' booklet provided to new residents and their

		whānau. Staff were noted to be wearing uniforms and name badges throughout the audit.
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	Carter Court has infection prevention (IP), and antimicrobial stewardship (AMS) programmes that are appropriate to the size and complexity of the service. Infection prevention and control (IPC) and AMS were part of the business and quality plans. The IP and AMS programmes were also linked to the quality improvement system, with results reviewed and reported. The IPC programme was reviewed annually, and significant issues were escalated through an effective communication pathway to the leadership and governance teams. Documentation reviewed evidenced significant events (eg, infection outbreaks) were escalated within 24 hours. The infection control team involved all staff, with input from the GP. Infection rates were presented and discussed at quality/management, health and safety, staff, and nurses' meetings (attended by RNs and ENs), with results reported to governance. Carter Court collected data on infections and antibiotic use across ethnicity to support equity in the IP and AMS programmes. A RN undertakes the role of infection control officer (ICO) to oversee infection control and prevention across the service. A job description outlined the responsibility of the role and the ICN had undertaken education to support the role. Access to IP and AMS support expertise is through the facility's GP, the IP clinical nurse specialist from Te Whatu Ora, 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	FA	The infection prevention and control policies reflected the requirements of the standard and are based on current accepted good practice. There was an infection prevention and antimicrobial stewardship programme in place that had been developed by those with IP expertise, was linked to the quality improvement programme and had been approved by the Carter Court governing body. Annual review of the programme, with

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.		reporting to governance, had occurred. The ICO was responsible for overseeing and implementing the IP programme with reporting lines to the NM and FM. The ICO had appropriate skills, knowledge and qualifications for the role and confirmed access to the necessary resources and support. Their advice, alongside the CM and FM, had been sought when making decisions around procurement relevant to care delivery, design of any new building or facility changes, and policies. All staff were familiar with policies, had completed orientation, and attended ongoing education (refer to criterion 2.3.4), and were observed to follow these correctly. An infection control induction resource had been developed for new staff. Cultural advice was accessed where appropriate. The ICO identified areas for improvement and developed infection prevention education posters three-monthly to inform staff. Residents and their whānau were educated about infection prevention in a manner that met their needs. Educational resources were available in te reo Māori. A pandemic/infectious diseases response plan was documented and had been regularly tested. There were sufficient resources and personal protective equipment (PPE) available, and staff had been trained accordingly. Staff were familiar with policies for decontamination of reusable medical devices and there was evidence of these being appropriately decontaminated and reprocessed. The process was audited to maintain good practice. Single-use medical devices were not reused.
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	FA	Responsible use of antimicrobials was promoted. The AMS programme was appropriate for the size and complexity of the service, supported by policies and procedures. The effectiveness of the AMS programme was evaluated by monitoring antimicrobial use and identifying areas for improvement.

appropriate to the needs, size, and scope of our services.		
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) was appropriate to that recommended for the type of services offered and was in line with risks and priorities defined in the infection control programme. Monthly surveillance data was collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme were shared with staff, reported back to governance and included ethnicity data. A summary report for two recent COVID-19 infection outbreaks in May and July 2024 were reviewed, and it demonstrated a thorough process for investigation and follow-up. Learnings from the event have been incorporated into practice and specific training provided to staff. Communication between service providers, and residents experiencing a health care-associated infection (HAI), was culturally safe.
Subsection 5.5: Environment The people: I trust health care and support workers to maintain a hygienic environment. My feedback is sought on cleanliness within the environment. Te Tiriti: Māori are assured that culturally safe and appropriate decisions are made in relation to infection prevention and environment. Communication about the environment is culturally safe and easily accessible. As service providers: We deliver services in a clean, hygienic environment that facilitates the prevention of infection and transmission of antimicrobialresistant organisms.	FA	Carter Court ensured a clean and hygienic environment supported prevention of infection and mitigation of transmission of antimicrobial-resistant organisms. Staff followed documented policies and processes for the management of waste and infectious and hazardous substances. Laundry and cleaning processes were managed on site and were monitored for effectiveness. The ICO has oversight of the environmental testing and monitoring programme. Staff involved had completed relevant training and were observed to carry out duties safely. Cleaners and laundry staff were supported by a housekeeping manager. Chemicals were stored safely. Residents and whānau reported that the laundry was managed well, and the facility was kept clean and tidy. This was confirmed through observations. The housekeeping manager and cleaning and laundry staff were interviewed and expressed their satisfaction in their positions at Carter Court and their commitment to maintaining a high standard of service for the residents was evident during the audit.

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	Carter Court is a restraint-free environment, the facility has not used restraint since the previous (surveillance) audit, and there were no residents observed to be using restraint during the audit. Policies and procedures met the requirements of the Standard and have been approved by the governing body. An EN, who reports to the NM (who is a RN) acted as the RC for the service. A job description was in place for the role and, while they have completed internal education in relation to restraint, no specific specialist education has been accessed (refer criterion 2.3.4). The legalities of the restraint process were understood by the RC, and restraint processes outlined in policy were understood by staff interviewed. Restraint education was part of the education programme, and this was delivered in 2024; however, only 25 from a possible 45 clinical staff have attended this education (refer criterion 2.3.4). Where staff have attended education, this has covered least restrictive practice, safe restraint practice, alternative cultural-specific interventions, de-escalation techniques (including behaviours that challenge), and restraint monitoring. Restraint is identified as part of the quality programme and reported at all levels of the organisation. The RC, in consultation with the multidisciplinary team, would be responsible for the approval of the use of restraints should this be required in the future; 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, the NM and the GP as part of the decision-making process. A paper-based restraint register was maintained; the criteria documented on the restraint register contains enough information to provide an auditable record of restraint should this be required. The RC undertakes a six-monthly review of all residents who may be at risk and outlines the strategies to be used to prevent restraint being required through the care planning process. Any changes to policies, guidelines, education and processes were implemented if indicated. Given no restraint was being used in the facility, subsections 6.2 and

		6.3 are not applicable and have not been audited.

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 2.2.4 Service providers shall identify external and internal risks and opportunities, including potential inequities, and develop a plan to respond to them.	PA Moderate	Early warning signs and risks that may adversely affect a person’s wellbeing were being recorded on the resident’s record, with a focus on prevention or escalation for appropriate interventions. The exception to this relates to post-fall monitoring. Eight incident forms related to unwitnessed falls were reviewed. The forms were fully completed, a post-fall assessment had taken place, and whānau had been informed of the event. However, following this, none of the residents had neurological observations completed as per the service’s policy and nursing best practice. In two instances, neurological observations were discontinued despite declining blood pressure readings.	Neurological observations had not been fully completed following a fall event.	Provide evidence that neurological observations have been fully completed following a fall event. 90 days
Criterion 2.3.4	PA Low	There is a documented education	Whilst there is an education	Provide evidence that a

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.		programme in place. While the programme itself is fit for purpose and covers the requirements set down by the Standard and the provider's agreements with Te Whatu Ora, there is no integrated recording system to record education undertaken by staff. There were numerous documents for recording education that has been delivered. Compulsory study days had good attendance rates. Subjects covered included pressure injury, neurodiversity/intellectual disabilities, Te Tiriti o Waitangi, falls prevention, infection control, elder abuse and neglect, and emergency and civil defence. Other than these, attendance was at or below 50% staff attendance, with 27 staff who had not attended any education in 2024. Staff had been involved in restraint education, with 26 staff completing this. The infection control coordinator (ICC) had completed education specific to the role. The restraint coordinator (RC), who is an enrolled nurse (EN), had documented evidence of internal training and good sound knowledge of restraint process; however, no specialised external training was evident. The education programme for 2025 has commenced with low numbers of participants so far.	programme in place, there are no effective processes in place to record delivery of the programme. Attendance at most of the programme is generally low, and 27 staff did not attend any of the education programme events in 2024. The RC has not had any specific education relevant to the restraint coordinator role.	system to accurately record education delivered has been implemented. Provide evidence that strategies to increase staff attendance of the education programme have been put into place, and that the RC has completed education specific to the restraint coordinator role. 180 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.