Presbyterian Support Southland - Peacehaven Village

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:	Presbyterian Support Southland
Premises audited:	Peacehaven Village
Services audited:	Hospital services - Psychogeriatric services; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 6 August 2025 End date: 7 August 2025

Proposed changes to current services (if any): The HealthCERT letter dated February 2025 stated the intention to reconfigure previous office /staff spaces into six hospital psychogeriatric beds. The hospital psychogeriatric bed numbers increased from 20 to 26 and was commissioned in March 2025, which also increased the overall bed numbers for PSS Peacehaven Village to 126 (there are also 4 double rooms suitable for couples). The additional rooms were verified as suitable for the intended use.

Total beds occupied across all premises included in the audit on the first day of the audit: 120

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
(blue)	Includes commendable elements above the required levels of performance	All subsections applicable to this service fully attained with some subsections exceeded
(green)	No short falls	Subsections applicable to this service fully attained
(yellow)	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

PSS Peacehaven Village is part of the Presbyterian Support Southland (PSS) Enliven organisation. The service is one of four aged care facilities governed by the PSS Trust Board. The service is certified to provide rest home, hospital (medical and geriatric), dementia, and psychogeriatric levels of care for up to 126 residents. There were 120 residents on the days of the audit.

This surveillance audit was conducted against a subset of the Ngā Paerewa Health and Disability Standard 2021 and contracts with Health New Zealand Te Whatu Ora. The audit process included a review of organisational and quality documentation; resident and staff files; observations; and interviews with residents, family/whānau, management, staff, and a nurse practitioner.

There has been no change in management since the last audit. Recent refurbishments were completed to add six additional beds to the psychogeriatric unit, which were verified as suitable at this audit.

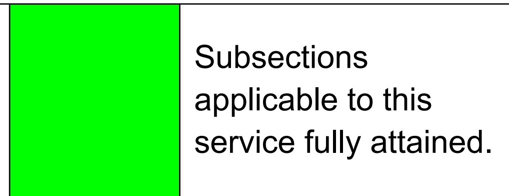
The facility manager is a registered nurse. They have been in the role since 2021 and has previous experience as a clinical manager within Presbyterian Support Southland. They are supported by a dementia services manager, clinical manager, clinical coordinator, quality manager and wider PSS management team. The healthcare assistants' workforce has remained stable within the facility.

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

There were no shortfalls at the previous audit.

This surveillance audit has identified shortfalls related to the registered nurse roster for the psychogeriatric unit and the documentation of medication effectiveness.

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.	

There is a Māori health plan in place for the organisation. Te Tiriti O Waitangi is embedded and enacted across policies, procedures, and delivery of care. The service recognises Māori mana motuhake and this is reflected in the Māori health plan and business plan. A Pacific health plan is in place which ensures cultural safety for Pacific peoples, embracing their worldviews, cultural, and spiritual beliefs. PSS Peacehaven Village demonstrates their knowledge and understanding of resident's rights and ensures that residents are well informed in respect of these. Residents are kept safe from abuse, and staff are aware of professional boundaries. There are established systems to facilitate informed consent and to protect resident's property and finances. The complaints' process is responsive, fair, and equitable. It is managed in accordance with the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights and complainants are kept fully informed.

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 low risk.

PSS Peacehaven Village has a well-established and robust governance structure, including clinical governance that is appropriate to the size and complexity of the service provided. The strategic plan includes a mission statement and operational objectives which are regularly reviewed. Barriers to health equity are identified, addressed and services delivered that improve outcomes for Māori. The service has effective quality and risk management systems in place that take a risk-based approach and progress is regularly evaluated against quality outcomes. There is a process for following the National Adverse Event Reporting policy and management have an understanding and comply with statutory and regulatory obligations in relation to essential notification reporting. There is a staffing and rostering policy. 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

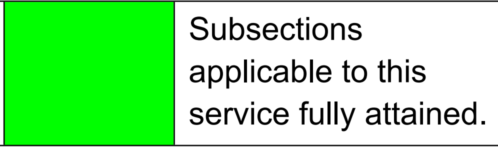
Includes eight subsections that support an outcome where people participate in the development of their pathway to wellbeing, and receive timely assessment, followed by services that are planned, coordinated, and delivered in a manner that is tailored to their needs.		Some subsections applicable to this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

The registered nurses assess, plan and review residents' needs, outcomes, and goals with the resident and/or family/whānau input. Care plans demonstrate service integration. Interventions are documented in detail to address medical, physical, social, and cultural needs. Resident files included medical notes by the contracted nurse practitioner/s and visiting allied health professionals.

All staff responsible for administration of medication complete education. The electronic medicine charts reviewed were reviewed at least three-monthly by the nurse practitioner. The kitchen staff cater to individual cultural and dietary requirements. The service has a current food control plan.

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 holds a current building warrant of fitness and current Certificate of Public Use. Electrical equipment has been tested and tagged. All medical equipment has been serviced and calibrated.

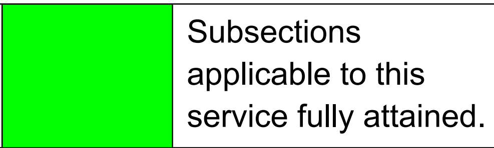
Te kaupare pokenga me te kaitiakitanga patu huakita | Infection prevention and antimicrobial stewardship

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

All policies, procedures, the pandemic plan, and the infection control programme have been developed and approved by management. Infection control education is provided to staff at the start of their employment, and as part of the annual education plan.

Surveillance data is undertaken, including the use of standardised surveillance definitions, and ethnicity data. Infection incidents are collected and analysed for trends and the information used to identify opportunities for improvements. Benchmarking occurs. There had been three outbreaks documented and managed since the last audit.

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.	

The restraint coordinator is the clinical manager. The facility has no residents using restraint. Restraint has been eliminated since the last audit. Minimisation of restraint use 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	17	0	1	1	0	0
Criteria	0	48	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	A Māori health plan is documented for the service, which Presbyterian Support Southland (PSS) Peacehaven Village utilises as part of their strategy to embed and enact Te Tiriti o Waitangi in all aspects of service delivery. At the time of the audit, the service had both residents and staff who identified as Māori. The service recognises Māori mana motuhake and this is reflected in the Māori health plan, and in the care plan of a resident who identified 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	The Pacific Health and Wellbeing Plan 2020-2025 is the basis of the PSS cultural safety for Pasifika Peoples and their Fonua policy. The principles/objectives of the policy are acknowledging Pacific people by maintaining respectful relationships, creating equitable access to services, valuing families, and provide high quality health care. The policy recognises Pacific models of care and include Kakaha, Fonofale and Fonua model of care. At the time of the audit there were residents who identified as Pasifika. There were Pacific staff who could confirm that cultural safety for Pacific peoples, their worldviews, cultural, and spiritual beliefs are embraced at PSS Peacehaven Village.

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	The Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is displayed in English and te reo Māori. The facility manager interviewed, demonstrated how it is also provided in welcome packs in the language most appropriate for the resident, to ensure they are fully informed of their rights. Interviews with seven family/whānau (four hospital, one from the specialised psychogeriatric unit (PG), one from the dementia unit and one from the rest home), and five residents (three hospital level care and two rest home level care) confirmed they are informed of their rights and their choices are respected.
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	The PSS organisational policies provide guidelines to prevent any form of institutional racism, discrimination, coercion, harassment, or any other exploitation. There are established policies, and protocols to respect resident's property, including an established process to manage and protect resident finances. All staff at PSS Peacehaven Village are trained in and aware of professional boundaries, as evidenced in orientation documents and ongoing education records. Twenty- one staff were interviewed (twelve healthcare assistants [HCAs], six registered nurses (RN), one enrolled nurse [EN], one cook, one maintenance /project team leader) and management (facility manager, quality manager, clinical manager, dementia services manager and clinical coordinator) demonstrated an understanding of professional boundaries when interviewed.
Subsection 1.7: I am informed and able to make choices The people: I know I will be asked for my views. My choices will be respected when making decisions about my wellbeing. If my choices cannot be upheld, I will be provided with information that supports me to understand why. Te Tiriti: High-quality services are provided that are easy to access and navigate. Providers give clear and relevant messages so that individuals and whānau can effectively manage their own health,	FA	Resident files reviewed included completed general consent forms and consents for influenza and Covid-19 vaccinations. Residents and family/whānau interviewed could describe what informed consent was and knew they had the right to choose. Consent forms were appropriately signed by the activated enduring power of attorney (EPOA) or welfare guardians. All documentation regarding EPOA, and the appropriate activation is on file; this was evident in the resident files reviewed.

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.		
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	The complaints procedure is provided to residents and 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. There have been two complaints made in 2024 which were resolved to the satisfaction of the complainant. One complaint was made through the Health and Disability Commissioner (HDC) in 2025, and the complaint has been closed and not substantiated. One complaint made through HDC in November 2021 has now been closed off in June 2024 by HDC. The Ministry requested follow up against aspects of the complaint that included: oxygen therapy management and fluid and nutrition management policies (criteria 2.2.2); and completion of staff training for oxygen management; fluid balance record keeping; compression stocking management; and privacy (criteria 2.3.2). This audit has identified no issues at this audit, related to the aspects of the complaint. One HDC complaint in July 2023 that was reported on in the previous audit, remains open. Complaints documentation reviewed included follow up and outcome letters demonstrated that complaints are being managed in accordance with guidelines set by HDC. The facility manager and quality manager are responsible for the management of complaints. Residents or 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 residents and family/whānau 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

		facility manager acknowledged their understanding that for Māori, there is a preference for face-to-face communication, and to include family/whānau participation.
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	PSS Peacehaven Village is part of the Presbyterian Support Southland (PSS) Enliven organisation. The service is one of four aged care facilities governed by the PSS Trust Board. The service is certified to provide rest home, hospital (medical and geriatric), dementia and psychogeriatric levels of care for up to 126 residents. At the time of the audit, the rest home and hospital wings have 80 dual purpose rooms, this includes four rooms suitable for couples. The dementia unit has a 20-bed capacity, and the psychogeriatric (PG) unit has a 20-bed capacity. The service has requested through Ministry of Health to increase the overall bed capacity from 124 to 130, increasing the PG unit from 20-bed capacity to 26 beds. This audit identified that the additional PG beds were suitable for use. On the days of audit there were 120 residents in total: 51 at hospital level care, including one resident on a long-term support chronic health condition contract (LTS-CHC); and one resident funded under an Accident Compensation Contract (ACC); 29 residents at rest home level of care; 18 residents in the secure dementia wing; and 22 residents in the secure PG wing. All other residents were funded under the Age-Related Residential Care Services Agreement (ARRC) or Aged Residential Hospital Specialised Services Agreement (ARHSS). There have been no changes in managers since the last audit. There is a PSS Charter and Strategic Plan 2021-2026 that documents the vision, values, and key service objectives. The chief executive and senior leadership team is responsible for delivery on the strategic plan objectives, and the documents evidence a commitment to regulatory and legislative obligations within the Enliven philosophy framework. Management reports on progress against the plan on a quarterly basis. The strategic plan reflects a leadership commitment to collaborate with Māori, aligns with the Ministry of Health strategies, and addresses barriers to equitable service delivery to improve positive outcomes for Māori. A clinical governance committee (created by the Trust Board) meets two-monthly, and reviews reports monthly. Its membership is from the Board,

		and externally with clinical expertise from a GP and two external nurse practitioners, who were added to the committee to extend clinical support. The quality improvement plan is reviewed three-yearly (with updates provided quarterly). The clinical governance committee reviews the risks for the PSS Enliven (aged care) service at their bi-monthly meetings, where this information is reported to the Board. Site specific goals relate to clinical effectiveness, effective cultural journey, and risk management is overseen and reported on by the quality manager. The facility manager is a RN and maintains an annual practising certificate. They have been in the role since 2021 and has previous experience as a clinical manager within PSS. They are supported by a dementia services manager, clinical manager, clinical coordinator, quality manager, and wider PSS management team. The healthcare assistants' workforce has remained stable within the facility. The facility manager has completed the required eight hours of professional development activities related to managing an aged care facility.
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.	FA	PSS Peacehaven Village is implementing a quality and risk management programme. The quality and risk management systems include performance monitoring through internal audits and through the collection of clinical indicator data. Quarterly quality and general staff meetings provide an avenue for discussions in relation to (but not limited to) quality data; health and safety; infection control/pandemic strategies; complaints; staffing; and education. Internal audits, meetings and collation of data were documented as taking place as scheduled. Clinical related internal audits are completed by the quality manager and facility manager (RN) and reported in the monthly clinical quality report, and monthly PSS clinical managers' meetings. Corrective actions were documented where indicated to address service improvements, and evidence of progress and sign off when achieved. Quality and health and safety goals and progress towards attainment are discussed at quality/risk and general staff meetings. Quality data and trends are added to meeting minutes. There was evidence of high staff attendance at meetings. Quality improvement projects included pain check implementation for residents in the dementia unit, and the use of pneumatic leg compression equipment to replace the use of compression stockings. All

		policies have been reviewed within the last two years. The medication management policy includes oxygen therapy management, and the fluid and nutrition management policies were reviewed and updated in October 2023 to reflect best practice. Monthly internal and quarterly external benchmarking of quality data, including ethnicity trends, provide a critical analysis to organisational practice and to improve health equity. The residents and family/whānau survey completed in February 2025 evidence overall satisfaction with service delivery. A health and safety system is in place. Hazard identification forms are completed electronically, and an up-to-date hazard and risk register was reviewed (sighted). Staff are kept informed on health and safety issues in handovers and meetings. Electronic entries are completed for each incident/accident, and immediate action is documented with any follow-up action(s) required, evidenced in a sample of twenty accident/incident records reviewed. Incident and accident data is collated monthly and analysed. Results are discussed in the quality/risk meeting, general staff meetings, and at handover. Each event involving a resident reflected a clinical assessment and a timely follow up by an RN. Any risks are identified, with action plans to minimise future risks. Discussions with the facility manager and clinical manager evidenced awareness of their requirement to notify relevant authorities in relation to essential notifications. There were events notified under Section 31 and the required Severity Assessment Code (SAC) reports to the Health Quality and Safety Commission. There have been three outbreak events reported.
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	PA Low	There is staffing requirements policy and procedure that describes rostering and staffing rations in an event of residents' acuity change and outbreak management. Presbyterian Support Southland policy includes the rationale for staff rostering and skill mix. Rosters reviewed evidenced that every effort is undertaken to ensure staff are replaced when sick. The facility manager works Monday to Friday and oversees the day-to-day operations of the dual-purpose area at PSS Peacehaven Village. The clinical manager and clinical coordinator provide oversight on clinical aspects of the service in the dual-purpose units and are rostered to ensure

managed to deliver effective person-centred and whānau-centred services.		coverage over seven days. All three managers share the clinical after hours on-call roster. They are supported by a 24/7 RN availability in the dual-purpose unit. The HCAs reported they felt supported, and the workload is manageable. The roster takes into consideration the design of the building. There are nine ENs that support service delivery. The dementia services manager oversees the secure dementia unit and PG unit. They are available for after-hours clinical support for the PG and dementia unit. The roster evidenced sufficient HCAs allocated to the roster to ensure residents are well supported. The registered nurse roster reviewed and review of notification forms to HealthCERT evidenced the service has not always been able to replace the RN on the afternoon or night shift in the PG unit, when replacement was required for short notice absences. The roster is overseen by the administrator and facility manager to ensure staffing is covered in each wing. There are separate staff dedicated to activities, kitchen, cleaning, and laundry. The facility manager and quality manager oversee the education attendance and training schedule. There is an annual education and training schedule being implemented. The education and training schedule lists compulsory training, which includes (but not limited to) cultural awareness training; nutrition and hydration; oxygen management; compression stocking as part of cardiorespiratory condition management; privacy; and confidentiality. All training has been completed as scheduled, and high attendance numbers are documented for each topic. Staff last attended cultural awareness training at their orientation in October 2024. Training statistics and staff education reports are completed monthly by PSS Enliven support office to ensure staff training is monitored effectively. Registered nurses are supported with opportunities though the online learning platform, and have completed critical thinking, early sepsis management, quality framework, and end of life care. Registered nurses and HCAs complete annual competencies (sighted) related to their roles. There are nine of the fifteen RNs that have interRAI competencies. The service supports and encourages HCAs to obtain a New Zealand Qualification Authority (NZQA) qualification. There are 79 HCAs employed. Eighty five percent of HCAs have obtained a level 3 and above. There are 26 HCAs working in the dementia and PG units, and all have completed

		their required NZQA dementia standards to work in both the dementia and PG units. There are online training and education and resources available on the intranet. An Enliven training policy is being implemented. All staff are required to complete competency assessments as part of their orientation.
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	Eight staff files (three RNs [including clinical manager and clinical coordinator], one cook and four HCAs) reviewed included evidence of completed orientation, training and competencies and professional qualifications on file where required. There are job descriptions in place for all positions that includes outcomes, accountability, responsibilities, authority, and functions to be achieved in each position. A register of practising certificates is maintained for all health professionals. The service has a role-specific 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 RNs and HCAs to provide a culturally safe environment for Māori. All staff who have been employed for a year or more have a current performance appraisal on file.
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	Seven resident files (three hospital, two rest home, one rest home dementia, and one psychogeriatric level care) were reviewed for this audit. The registered nurses complete an initial assessment and care plan on admission to the service, under the banner of getting to know me assessment tool. There is evidence of resident and family/whānau involvement in the interRAI assessments and long-term care plan. Initial care plans, interRAI assessments and long-term care plans were completed within the stated timeframes of the contract. The care plans on the electronic resident management system were resident focused and individualised. All long-term care plans reviewed identified all support needs, goals, and interventions to manage medical needs/risks. Other available information, such as discharge summaries, medical and allied health notes, and consultation with the resident, family/whānau or significant others are included in the resident electronic

		file. The files reviewed for the residents in the dementia unit and PG unit`s care plan and twenty-four-hour diversional therapy plan was comprehensive and contained detailed triggers and early warning signs for escalating behaviours and specific interventions around managing triggers and deescalating behaviours. Care plans had been evaluated within the required six-month timeframe. Risk assessments that are completed six-monthly or earlier due to health changes. Care plans have been updated when there were changes in health condition and identified needs. A nurse led primary care practice (Nurse Practitioners [NP]) is contracted to provide medical service to residents four hours a week. The NP visits twice weekly and is available as needed. The NP completes medical admissions, three-monthly reviews and sees all residents of concern. The NP interviewed stated that the nursing team demonstrates competence with their assessments and referrals. The NP added that the residents added onto the list with acute problems are all appropriate. The NP commented positively on the care the residents received. Residents' electronic files identify the integration of NP and allied health professional input into care, and a multidisciplinary team approach is evident. A physiotherapist is contracted, and PSS contracted dietitian is available by referral. A podiatrist visits six-weekly. Other allied health professionals involved in care include hospice, clinical nurse specialists, and medical specialists from Health New Zealand. Healthcare assistants interviewed could describe a verbal and written handover at the beginning of each duty that maintains a continuity of service delivery. Progress notes are written each shift by the HCAs. The registered nurses write weekly clinical summary notes and complete progress notes more frequently if needed to reflect an accurate presentation of the current health status of the residents. Residents interviewed reported their needs and expectations were being met. When a resident's condition alters, the clinical manager or clinical coordinator initiates a review with the NP. Family/whānau or EPOA were notified of all changes to health, including infections, accident/incidents, NP visits, medication changes, and any changes to health status. A sample of wounds reviewed included facility-acquired stage II pressure injuries, skin tears, graze, skin lesions. The electronic wound care plan

		documents the wound management plans, assessments, and evaluations, with supporting photographs. Review of wounds and dressing changes occur as specified in the plans. Referrals are completed to the wound nurse specialist for additional input for complex wounds. Healthcare assistants interviewed stated there are adequate clinical supplies and equipment provided, including continence, wound care supplies, and pressure injury prevention resources. There is also access to a continence specialist as required. Care plans reflect the required health monitoring interventions for individual residents, including repositioning; intentional grounding; food and fluid; bowel chart; blood pressure; weight; pain; behaviour; neurological observations; and blood sugar levels. Monitoring charts reviewed were completed as scheduled. Short term acute issues are addressed in care plans and progress notes where appropriate.
Subsection 3.4: My medication The people: I receive my medication and blood products in a safe and timely manner. Te Tiriti: Service providers shall support and advocate for Māori to access appropriate medication and blood products. As service providers: We ensure people receive their medication and blood products in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Moderate	Medication management policies are available for safe medicine management. All staff (registered nurses, enrolled nurses, and medication competent HCAs) who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided. Staff were observed to be safely administering medications. Healthcare assistants could describe their role regarding medication administration. All medications are checked on delivery against the medication chart and any discrepancies are fed back to the supplying pharmacy. Regular physical checks and reconciliation of medication occurs. Medications were appropriately stored across five treatment rooms. The temperature monitoring of all treatment rooms and medication fridges were completed daily and readings were within the acceptable ranges. All medications, including the bulk supply order, are checked weekly. All eyedrops have been dated on opening. Fifteen electronic medication charts were reviewed (sample extend by one). The medication charts reviewed identified that the NP reviewed all resident medication charts three-monthly, and each chart has photo identification and allergy status identified. One resident self-administers their own inhaler. The facility follows their resident self-managing medication policy. The NP reviews the competency of the resident to self-administer their medication

		on a three-monthly basis. No standing orders are in use. Pro re nata (PRN) medications are charted and administered when required; however, not all administered prn medications were monitored for effectiveness or outcome. Residents and family/whānau are updated around medication changes, including the reason for changing medications and side effects. This is documented in the progress notes.
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 meals at PSS Peacehaven Village are all prepared and cooked on site. The kitchen was observed to be clean, well-organised, well equipped, and a current approved food control plan expires on 11 June 2026. The cook receives resident dietary information (including food allergies) from the RNs on admission, and is notified of any changes to dietary requirements. Dislikes and special dietary requirements (vegetarian, dairy free, pureed foods) are accommodated. The cook reports they accommodate residents' requests.
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	Planned discharges or transfers were coordinated in collaboration with residents and family/whānau to ensure continuity of care and to manage associated risks. Resident change, transfer, or termination policy and procedures are documented to ensure discharge, or transfer of residents is undertaken in a timely and safe manner. The registered nurses explained the transfer between services includes a comprehensive verbal handover and the completion of specific transfer documentation.
Subsection 4.1: The facility The people: I feel the environment is designed in a way that is	FA	There is a current building warrant of fitness and a certificate of public use (that includes the six additional beds). The environment is inclusive of

safe and is sensitive to my needs. I am able to enter, exit, and move around the environment freely and safely. Te Tiriti: The environment and setting are designed to be Māori-centred and culturally safe for Māori and whānau. As service providers: Our physical environment is safe, well maintained, tidy, and comfortable and accessible, and the people we deliver services to can move independently and freely throughout. The physical environment optimises people's sense of belonging, independence, interaction, and function.		peoples' cultures and supports cultural practices. A full-time maintenance and projects team leader oversees maintenance of the site, a team of four maintenance workers, and contractor management. Essential contractors, such as plumbers and electricians, are available 24 hours a day, every day as required. There is an annual maintenance plan that includes electrical testing and tagging, resident's equipment checks, call bell checks, calibration of medical equipment, and monthly testing of hot water temperatures. Visual checks of all electrical appliances belonging to residents are checked when they are admitted. Testing and tagging of resident`s electrical equipment is completed annually. Checking and calibration of medical equipment, hoists and scales is completed annually. Records and asset register is kept and managed by the maintenance and projects team leader, and is presented during the day of audit. There are three units 'upstairs' Kalimos, Robertson and Elliot (all dual-purpose). The Iona units (dementia and psychogeriatric) are on the ground floor. A reconfiguration letter dated February 2025 stated the intention to reconfigure a previous office /staff room into six hospital psychogeriatric beds. The hospital psychogeriatric bed numbers increased from 20 to 26, and was commissioned in March 2025, which also increased the overall bed numbers for PSS Peacehaven Village to 126 (there are also four double rooms suitable for couples). The rooms are single occupancy, and all share a communal toilet and shower. Handrails are appropriately placed in the communal toilet and shower. There were call bells next to the beds, enough space for equipment, and two staff members to provide care. The fixtures, fitting, flooring, and ventilation is suitable. There is a nurses' station, separate lounge, and dining room for these additional beds. There are separate hand hygiene facilities for staff to use. Flowing soap and alcogel is accessible. There is a risk assessment and protocols in place to mitigate the risk of infection related to commode use, as the sluice is not in close proximity from the new added beds. The new additional six beds were verified as suitable for hospital psychogeriatric level of care.
Subsection 4.2: Security of people and workforce	FA	The evacuation scheme is current and approved in February 2021, recently

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.		reviewed with no changes. The reconfiguration of the PG beds did not require a change in the evacuation scheme; this was confirmed by the maintenance and projects team leader. A fire drill was conducted prior to the audit.
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	There is a defined and documented infection control (IC) programme implemented that was developed with input from external IC services and reviewed annually. The IC programme was approved by the clinical governance committee and is linked to the organisation wide risk programme. The infection control manual outlines a comprehensive range of policies, standards and guidelines, and includes defining roles, responsibilities and oversight, the infection control team, and training and education of staff. The infection control coordinator is a registered nurse (clinical coordinator), who has completed infection control training related to their role. The pandemic plan is available for all staff and includes scenario-based training completed at intervals. Staff education includes (but is not limited to): standard precautions; isolation procedures; hand hygiene competencies; and donning and doffing personal protective equipment (PPE). All staff have completed the required training within the last 12 months.
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,	FA	Infection surveillance is an integral part of the infection control programme and is described in the infection control policy manual. Monthly infection data is collected for all infections based on signs, symptoms, and definition of infection. Infections are entered into the register on the electronic database and surveillance of all infections (including organisms) is collated onto a monthly infection summary. This data is monitored and analysed for trends, monthly and annually. Benchmarking occurs. The service incorporates ethnicity data into surveillance methods and data captured around infections. Infection control surveillance is discussed at quality/risk and staff meetings. Meeting minutes and graphs are displayed for staff.

and methods specified in the infection prevention programme, and with an equity focus.		Action plans are required for any infection rates of concern. Internal infection control audits are completed with corrective actions for areas of improvement. The service receives regular notifications and alerts from Health New Zealand. Infections, including outbreaks, are reported, and reviewed, so improvements can be made to reduce healthcare acquired infections (HAI). Education includes monitoring of antimicrobial medication, infection control, aseptic technique, and transmission-based precautions. Three outbreaks were documented since the last audit and records evidence these were well documented and managed.
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	The governance body demonstrate a commitment to eliminating restraint and all restraint use were eliminated since the last audit. The facility maintains a focus on ensuring care is provided in the least restrictive way possible. There were no residents using restraint. A registered nurse undertakes the restraint portfolio and drives the ongoing philosophy of eliminating restraint. The restraint policy confirms that restraint consideration and application must be made in partnership with family/whānau, and the choice of the device must be the least restrictive possible. When restraint is considered, the facility works in partnership with the resident and family/whānau to ensure services are mana-enhancing. Training for all staff occurs at orientation and annually, as sighted in the training records. Staff have been trained in the least restrictive practice, safe restraint practice, alternative cultural-specific interventions, and de-escalation techniques. Restraint competencies are completed on orientation and annually.

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 2.3.1 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 Low	The roster is overseen by the administrator and facility manager to ensure staffing is covered in each wing. There is staffing requirements policy and procedure that describes rostering and staffing rations in an event of residents’ acuity change and outbreak management. Presbyterian Support Southland policy includes the rationale for staff rostering and skill mix. Rosters reviewed evidenced that every effort is undertaken to ensure staff are replaced when sick. There are separate staff dedicated to activities, kitchen, cleaning, and laundry. The roster evidence sufficient HCAs allocated to the roster to ensure residents are well supported. The registered nurse roster reviewed and review of notification forms between January 2025 and July 2025 to HealthCERT evidence the service has not	The organisation could not replace recent short-term RN absences in the psychogeriatric unit with another RN for pm and night shift.	Ensure that contractual obligations related to ARHHS clause 17.3(b) and 17.4 (a) are met for the psychogeriatric unit`s roster requirements. 90 days

		always been able to replace the RN in the afternoon or on night shift in the PG unit, when replacement was required for short notice absences. Risk mitigation strategies were developed and implemented and include an experience EN to replace the RN; they were also supported by experienced HCAs, who will support medication administration. There were registered nurses within the building in the dual-purpose units; however, the roster does not meet the contractual requirements of the ARHHS contract.		
Criterion 3.4.1 A medication management system shall be implemented appropriate to the scope of the service.	PA Moderate	PSS Peacehaven Village has medication policies and procedures documented that align with current legislation and best practice. An electronic medications system is utilised. All medication charts are documented appropriately and include photographic identification. Allergies and sensitivities are all documented clearly. Medications are checked on delivery and any errors are reported to the pharmacy. There are no expired medications on site. All medications are stored appropriately in five treatment rooms and five locked medication trolleys stored in the treatment rooms. Room and fridge temperatures have been monitored and within acceptable ranges. All medication charts (three hospital, three rest home, four dementia rest home, and five psychogeriatric levels of care) sampled evidence of prn administration; however, review of administered PRN medications for effectiveness were not consistently evaluated.	Nine out of nine medication charts reviewed (in the dementia unit and PG unit) indicate administration of prn medications; however, effectiveness was not consistently documented in the medication electronic system or in the resident progress notes.	Ensure that effectiveness /outcomes of administered prn medications are documented. 60 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.