Christchurch Methodist Central Mission - WesleyCare

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:	Christchurch Methodist Central Mission
Premises audited:	WesleyCare
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 11 September 2025 End date: 12 September 2025

Proposed changes to current services (if any):

Total beds occupied across all premises included in the audit on the first day of the audit: 101

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

WesleyCare is a division of Christchurch Methodist Mission (CCM) and provides care for up to 108 residents at hospital (geriatric and medical) and rest home levels of care. All beds are dual purpose. On the day of the audit, there were 101 residents.

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 general practitioner.

Clinical oversight is provided by the clinical coordinators. They are supported by a divisional manager (facility manager) and a quality manager. The healthcare assistants` workforce has remained stable within the facility.

There are quality systems and processes documented. 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.

Three of three previous shortfalls identified at the previous audit related to clinical governance, performance of equipment and monitoring of restraint have been addressed.

This surveillance audit has identified shortfalls related to the implementation of aspects of the quality and risk management system, implementation of good employment practices and infection surveillance.

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.

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. WesleyCare 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.

WesleyCare 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 a documented 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.		Subsections applicable to this service fully attained.

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. Resident files included medical notes by the contracted general practitioner and visiting allied health professionals. Medication policies reflect legislative requirements and guidelines. All staff responsible for administration of medication complete education and medication competencies. The electronic medicine charts reviewed met prescribing requirements and were reviewed at least three-monthly by the general practitioner. The kitchen staff cater to individual cultural and dietary requirements. The service has a current food control plan. All residents' transfers and referrals are coordinated with residents and families/whānau.

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 holds a current building warrant of fitness. 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.		Some subsections applicable to this service partially attained and of low risk.

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. There had been two 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.		Subsections applicable to this service fully attained.

The facility had no residents using restraints at the time of 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	16	0	3	0	0	0
Criteria	0	48	0	3	0	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 WesleyCare 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. Six managers (executive director, assistant manager, compliance manager, quality manager and two clinical coordinators) interviewed confirmed Te Tiriti o Waitangi is embedded in the service.
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	FA	The Pacific Health and Wellbeing Plan 2020-2025 is the basis of the WesleyCare's Pacific Peoples' Health policy and procedure. The aim is to uphold the principles of Pacific people by acknowledge respectful relationships, valuing families and provide high quality healthcare. The Pacific Peoples' Health policy and procedure objective states WesleyCare's commitment to supporting Pacific residents and their family/whānau. 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,

peoples for improved health outcomes.		Fonofale and Fonua model of care. At the time of the audit there were residents who identified as Pasifika. There were Pacific staff who confirmed that cultural safety for Pacific peoples, their worldviews, cultural, and spiritual beliefs are embraced at WesleyCare.
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 clinical coordinators 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 three family/whānau (three hospital), and five residents (four hospital and one rest home) 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	WesleyCare 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 WesleyCare are trained in and aware of professional boundaries, as evidenced in orientation documents and ongoing education records. Thirteen staff were interviewed (five healthcare assistants [HCAs], five registered nurses (RN), one cook, Māori hakui and the human resources coordinator) demonstrated an understanding of professional boundaries when interviewed. The divisional manager (facility manager) was not available to partake in the audit process.
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	FA	There are policies around informed consent that meet the requirements of the Code. Resident files reviewed included completed general consent forms and consents for influenza and other 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

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.		activation is on file; this was evident in the resident files reviewed.
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 three complaints made since the previous audit in February 2024. All complaints were resolved to the satisfaction of the complainant. There were no external complaints received from any agencies. Complaints documentation reviewed included follow up and outcome letters demonstrated that complaints are being managed in accordance with guidelines set by the Health and Disability Commissioner (HDC). The divisional 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 quality manager and clinical coordinators 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	FA	WesleyCare is a division of Christchurch Methodist Mission (CCM) and provides care for up to 108 residents at hospital (geriatric and medical)

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.		and rest home levels of care. All beds are dual purpose. On the day of the audit, there were 101 residents: 38 residents at rest home level, including one on a long-term support chronic health condition contract (LTS-CHC); and 63 at hospital level, including one on an end of life contract (EOL), three under 65 years of age on a close in age need contract, one on respite care, and one on a LTS-CHC contract. The remaining residents were on the aged related residential care services contract (ARRC). All rooms were single occupancy. There has been a change in reporting structure since the last audit. There is a Christchurch Methodist Mission (CMM) Strategic Plan 2023-2026 and WesleyCare Business plan (2024-2025) that documents the vision, values, and key service objectives. The organisational business documents include partnering with Māori, government, and other businesses to align their work with and for the benefit of Māori. WesleyCare objectives include strategies to address barriers to equitable service delivery to improve positive outcomes for Māori. The executive director is responsible for delivery on the strategic plan, and the documents evidence a commitment to regulatory and legislative obligations within the CMM philosophy framework. The executive director and divisional manager reports on progress against the plan monthly. The clinical governance is overseen by a registered nurse on the Board. The Board meets seven times a year. The executive director receives monthly quality reports from the divisional and quality manager to include in the monthly Board reports, and included antimicrobial stewardship and restraint. The previous audit finding related to criteria # 2.1.11 has been addressed. Clinical oversight is provided by two full-time clinical coordinators that have been with WesleyCare for more than five years. They completed a clinical report weekly and meets with the divisional manager weekly. The quality manager (registered nurse) supports the implementation of the quality programme and provide analysis of data. The healthcare assistants' workforce has remained stable within the facility. The management team 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.	PA Low	The quality manager oversees the implementation of the quality and risk management system. WesleyCare has moved in June 2025 to electronic management system. The service is still in the process of embedding the new policies, documents and procedures. A transition plan in documented to amalgamate the hybrid systems that are currently still in place, with a completion date documented as December 2025. The quality and risk management systems include performance monitoring through internal audits and through the collection of clinical indicator data. Monthly 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. Meetings and collation of data were documented as taking place as scheduled. Meeting minutes for 2025 evidence that there is not always a person allocated to address corrective actions following from the meetings. The quality and risk management system for 2024, including restraint, antimicrobial stewardship and infection control annual programme, was reviewed in December 2024. The internal audit schedule for 2024 and the internal audit results were not available on the days of the audit. Not all meeting minutes for 2024 evidence detailed discussions on the performance of the quality and risk management system. Corrective actions related to internal audits for 2025 were documented where indicated to address service improvements and evidence of progress and sign off when achieved. Quality, 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. Trends in infection related data were identified; however, no improvement plan was evidenced as being documented to identify contributing factors and interventions to improve (link 5.4.4). Monthly internal and 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 May/June 2025 evidence overall satisfaction (met or exceed expectations) 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 accident/incident records reviewed. Incident and accident data is collated monthly and analysed. Results are discussed in the quality meeting and 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 quality manager and clinical coordinators evidenced awareness of their requirement to notify relevant authorities in relation to essential notifications. Section 31 notifications and the required Severity Assessment Code (SAC) reports to the Health Quality and Safety Commission were completed as required. There have been two outbreak events reported since the last audit.
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.	FA	There is staffing requirements policy and procedure that describes rostering and staffing rations in an event of residents' acuity change and outbreak management. WesleyCare 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 clinical coordinators work full time and across seven days to ensure clinical oversight. There is a duty leader (registered nurse) on the afternoon and night shift with additional RNs to support. The divisional manager is on call for operational issues. The clinical and non-clinical rosters reviewed evidence enough staff to deliver services. The HCAs reported they felt supported, and the workload is manageable. The roster takes into consideration the design of the building. There is separate fluid assistants and dining room assistants on duty. Staff reported that short notice absences are replaced by a casual pool of staff or regular agency staff. The roster is overseen by the roster administrator to ensure staffing is covered in each wing. There are separate staff dedicated to activities, kitchen, cleaning and laundry. The quality manager oversees 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; abuse and neglect, sexuality and intimacy, skin management and pressure injury prevention; and privacy and confidentiality. All training has been completed as scheduled and high attendance numbers are documented for each topic. Staff attended cultural awareness training in 2024 and 2025. Training statistics and staff education reports are completed monthly by quality manager to ensure staff training is completed. Registered nurses are supported with opportunities though the online learning platform and have completed critical thinking, palliative care, and early sepsis management. Registered nurses and HCAs complete annual competencies (sighted) related to their roles and the competencies were current where required. There are 15 of 22 RNs that have interRAI competencies. The service supports and encourages HCAs to obtain a New Zealand Qualification Authority (NZQA) qualification. There are 75 HCAs employed. Seventy-seven percent of HCAs have obtained a level 3 and above.
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.	PA Low	Eight staff files (three RNs [including two clinical coordinators], lead cook and four HCAs) were reviewed. The quality manager provided a spread sheet of completion dates of orientation, completed competencies and performance appraisals; however, seven of the individual files reviewed did not evidence the integration of individual training records, current competencies, performance appraisals and orientation records. The human resource coordinator stated the service moved to an electronic system within the last six months. The paper records were not easily available and accessible. Criteria 2.4.1 was opened for this audit to ensure the service improves their procedures to meet good employment practice. 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. 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 completed.
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 were reviewed: four hospital (including one on respite and EOL contracts) and three rest home (including one LTS-CHC). The registered nurses (RN) are responsible for all residents' assessments, care planning and evaluation of care. Care plans are based on data collected during the initial nursing assessments which include information from pre-entry assessments. All residents, except the residents on respite care and EOL contracts, had an interRAI assessment, in addition to a full suite of assessments contained in the electronic resident management system, which incorporate, skin integrity, pressure injury risk, dietary requirements, communication needs, emotional, psychological, and behavioural support needs. The two residents on the respite and EOL contracts have a full suite of a combination of electronic and paper-based assessments completed soon after admission, and reviewed if health needs change (weekly for resident on EOL contract). Assessments include (but are not limited to) falls, pressure injury risk, pain, mobility, cognition, behaviour, nutrition and cultural spiritual. The long-term care plans were comprehensive, promote independence and were individualised. Initial assessments and long-term care plans were completed for residents, detailing needs, and preferences within 24 hours of admission. The individualised long-term care plans (LTCP) are developed with information gathered during the initial assessments and the interRAI assessment. All LTCP and interRAI assessments sampled had been completed within three weeks of the residents' admission to the facility. Documented interventions and early warning signs meet the residents' assessed needs and are sufficiently detailed to provide guidance to care staff in the delivery of care. Short-term care plans are developed for acute problems, for example infections, wounds and weight loss. Resident care is evaluated on each shift and reported at handover and in the progress notes. If any change is noted, it is reported to the RN. Long-term care plans are formally evaluated every six months in conjunction with the interRAI re-

		assessments, and when there is a change in the resident's condition. Evaluations are documented by an RN and include the degree of achievement towards meeting desired goals and outcomes. Residents interviewed confirmed assessments are completed according to their needs and in the privacy of their bedrooms. There was evidence of family involvement in care planning and documented ongoing communication of health status updates. Family interviews and resident records evidenced that family/whānau are informed where there is a change in health status. Multidisciplinary meetings involving families/whānau are completed six-monthly. The service has policies and procedures in place to support all residents to access services and information. The service supports and advocates for residents with disabilities to access relevant disability services. The service has three general practitioners (GP) contracted from the same GP practice, and each GP visits once weekly. A GP is available for advice after hours for residents with complex needs, but the local 24-hour after-hours service is used for after-hours support. The initial medical assessment is undertaken by the GP within the required timeframe following admission. Residents have ongoing reviews by the GP within required timeframes and when their health status changes. Medical documentation and records reviewed were current. The GP interviewed described how the facility operates at a high standard and is generally proactive in seeking support. A physiotherapist is contracted for weekly visits (two days) and on request to review residents referred by the RNs. There is access to continence and palliative care specialists as required. A podiatrist visits regularly and a dietitian, speech language therapist, wound care nurse specialist and medical specialists are available as required through Health New Zealand. An adequate supply of wound care products was available at the facility as sighted. A review of the wound care plans evidenced that wounds were assessed in a timely manner and reviewed at appropriate intervals. Photos were taken where this was required. Where wounds required additional specialist input, this was initiated, and a wound nurse specialist was consulted. At the time of the audit there were 23 active wounds, including skin tears, a chronic ulcers, skin lesions, abrasions and pressure injuries (present on admission and facility acquired). Adverse events were completed for pressure injuries, closed off when fully investigated, and

		corrective actions are included in the care plan. The progress notes are recorded and maintained in the integrated clinical records. Monthly observations such as weight and blood pressure were completed and are up to date. Neurological observations are recorded following unwitnessed falls as per policy. Staff interviews confirmed they are familiar with the needs of all residents in the facility, and that they have access to the supplies and products they require to meet those needs. Staff receive handover at the beginning of their shift.
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	There are policies available for safe medicine management that meet legislative requirements. All staff who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided as part of the competency process. Registered nurses have completed syringe driver training. Staff were observed to be safely administering medications. The RNs and medication competent caregivers interviewed could describe their role regarding medication administration. The service currently uses an electronic medication management system, and robotics medication sachet packs. All medications are checked on delivery against the medication chart and any discrepancies are fed back to the supplying pharmacy. Medications were appropriately stored in the facility medication room (one on each floor). The medication fridge and medication room temperatures are monitored daily. All stored medications are checked weekly and have a six-monthly pharmacy check. Eyedrops are dated on opening. Fourteen electronic medication charts were reviewed. The medication charts reviewed identified that the GP had reviewed all resident medication charts three-monthly, and each drug chart has photo identification and allergy status identified. Indications for use were noted for pro re nata (PRN) medications, including over-the-counter medications and supplements on the medication charts. The effectiveness of PRN medications was consistently documented in the electronic medication management system and progress notes. There were nine residents who self-administer medications. The procedures and policy regarding competence had been followed, and safe storage for medications was in place. No vaccines are kept on site, and no standing orders are used.

		There was documented evidence in the clinical files that residents and family/whānau are updated around medication changes, including the reason for changing medications and side effects.
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	Food preferences and cultural preferences are encompassed into the menu. The kitchen receives resident dietary forms and is notified of any dietary changes for residents. Dislikes and special dietary requirements are accommodated, including food allergies. The kitchen manager interviewed reported they accommodate residents' requests. There is a verified food control plan, expiring 25 September 2025. The residents and family/whānau interviewed were complimentary regarding the standard of food provided.
Subsection 3.6: Transition, transfer, and discharge The people: I work together with my service provider so they know what matters to me, and we can decide what best supports my wellbeing when I leave the service. Te Tiriti: Service providers advocate for Māori to ensure they and whānau receive the necessary support during their transition, transfer, and discharge. As service providers: We ensure the people using our service experience consistency and continuity when leaving our services. We work alongside each person and whānau to provide and coordinate a supported transition of care or support.	FA	There were documented policies and procedures to ensure discharging or transferring residents have a documented transition, transfer, or discharge plan, which includes current needs and risk mitigation. Planned discharges or transfers were coordinated in collaboration with the resident (where appropriate), family/whānau and other service providers to ensure continuity of care.
Subsection 4.1: The facility The people: I feel the environment is designed in a way that is safe and is sensitive to my needs. I am able to enter, exit, and move around the environment freely and safely. Te Tiriti: The environment and setting are designed to be	FA	The environment is inclusive of people's cultures and supports cultural practices. The buildings, plant, and equipment are fit for purpose at WesleyCare and comply with legislation relevant to the health and disability services being provided. The building warrant of fitness is current, with the expiry date 1 January 2026.

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.		The compliance manager and maintenance coordinator are responsible for maintaining the building and grounds. WesleyCare has an annual maintenance plan which includes electrical testing and tagging, equipment checks, call bell checks, calibration of medical equipment, and monthly testing of hot water temperatures. The documentation presented by the compliance manager during interview evidenced completion of the tests and monitoring required as per plan. The test and tag, calibration and compliance testing of medical and electrical equipment (including resident owned) were recently completed by external contractors. The previous audit finding related to non–compliance to complete checks of all electrical and medical equipment for safe use (criteria #4.1.1), has been addressed.
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 an external consultant and the quality manager 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	PA Low	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

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.		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 and staff meetings. Meeting minutes and graphs are displayed for staff. Action plans are required for any infection rates of concern; however, this has not been identified for the high levels of skin infections identified over the past there months. 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). Two outbreaks were documented since the last audit, and records evidence these were well 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 restraints were eliminated since February 2025. One of the clinical coordinators is the restraint coordinator. The restraint coordinator and RNs interviewed described the focus on ensuring care is provided in the least restrictive way possible. This approach was supported by the quality manager. 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. The facility works in partnership with Māori, to promote and ensure services are mana enhancing. At the time of the audit, there were no residents utilising restraint. Restraint elimination is included as part of the mandatory training plan and orientation programme.
Subsection 6.2: Safe restraint The people: I have options that enable my freedom and ensure my care and support adapts when my needs change, and I trust that the least restrictive options are used first. Te Tiriti: Service providers work in partnership with Māori to	FA	The documented policies that guide the use of restraint include the monitoring frequencies required for each type of approved restraint. The restraint coordinator will determine the frequency and rationale if it is changed from policy requirements. Restraint has been eliminated since the last audit; therefore, there were no requirements for monitoring of any

ensure that any form of restraint is always the last resort. As service providers: We consider least restrictive practices, implement de-escalation techniques and alternative interventions, and only use approved restraint as the last resort.		restraint. The previous audit finding related to criteria # 6.2.2 has been addressed.

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 2.2.2 Service providers shall develop and implement a quality management framework using a risk-based approach to improve service delivery and care.	PA Low	Meetings have occurred as scheduled. The meeting minutes except two (August and November 2024) provided detailed content of discussions, but stated in the sections only to `refer to data provided’ or ‘refer to internal audit schedule completed’. There was an internal audit schedule documented for 2024. An annual review of the infection control and antimicrobial stewardship programmes and the restraint programme were documented; however, the internal audit results for 2024 were not available and were not documented as part of discussions in the quality meetings. The internal audit schedule for 2025	(i). The internal audit results were not available for 2024. (ii). There was no evidence in the 2024 meeting minutes, except for two meeting minutes (August 2024 and November 2024), that detailed discussions around the performance of the quality programme with staff occurred. (iii). The meeting minutes for 2025 identified discissions related to the performance of the quality programme; however, corrective actions following from the meetings were not always assigned to a member of staff to follow up and sign off.	(i). -(iii). Ensure that all key aspects of the quality and risk management system is available, documented, followed up and discussed with staff. 90 days

		was implemented as scheduled and corrective actions followed from the meetings were documented; however, there was not always a person assigned to complete and sign off the corrective action.		
Criterion 2.4.1 Service providers shall develop and implement policies and procedures in accordance with good employment practice and meet the requirements of legislation.	PA Low	There are spreadsheets available to view for completion dates of competencies (including first aid certificates, interRAI competencies) and performance appraisals, which evidence that all are completed. Interviews with HCAs, clinical coordinators and the quality coordinator provided confidence that the procedures are completed. The quality manager provided a spreadsheet of completion dates of orientation, completed competencies and performance appraisals; however, seven of the individual files reviewed did not evidence the integration of individual training records, current competencies, performance appraisals and orientation records. The human resource coordinator stated the service moved to an electronic system within the last six months. The previous paper records were not easily available and accessible.	Seven of the individual files reviewed did not evidence the integration of individual training records, current competencies, performance appraisals and orientation records within the individual employment file. The paper records were not easily accessible and available.	Ensure individual training, competencies, performance appraisal and orientation records are integrated into the individual`s employment file. 90 days
Criterion 5.4.4 Results of surveillance and recommendations to improve	PA Low	The infection control committee meets three monthly; however regular monthly reports are discussed in the quality and	A trend has been identified related to a high number of skin and soft tissue infections; however, there	Ensure that where trends in infection rates are identified, a quality

performance where necessary shall be identified, documented, and reported back to the governance body and shared with relevant people in a timely manner.		RN/clinical meetings related to infection prevalence. The data collated, benchmarking data and meeting minutes evidence skin infections for the last three months has been identified at a rate of 0.65 per 1000 bed days which is three times higher than the industry standard of 0.2 per 1000 bed days.	were no recommendations documented to work towards the decrease in the prevalence of the type of infections.	improvement plan is documented to improve the performance. 90 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.