Heritage Lifecare Limited - Annie Brydon Lifecare

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Heritage Lifecare Limited
Premises audited:	Annie Brydon Lifecare
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 30 September 2025 End date: 1 October 2025

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 63

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

Annie Brydon Lifecare is certified to provide rest home and hospital services for up to 71 residents. The service is owned and operated by Heritage Lifecare Limited. Residents and whānau were complimentary about the care provided.

This certification audit was conducted against the Ngā Paerewa Health and Disability Services Standard NZS 8134:2021 and the contracts held with Health New Zealand – Te Whatu Ora. The process included a pre-audit assessment of policies and procedures, a review of residents' and staff files, observations, and interviews with residents and whānau, two governance representatives, management, staff, a nurse practitioner, and other health professionals. The facility is managed by an experienced care home and village manager, supported by an experienced clinical services manager who has clinical oversight of the facility.

Strengths of the service, resulting in continuous improvement ratings, related to changes to the admission process for residents and whānau and considerations in the management of palliative care. No areas requiring improvement were identified during the audit.

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.

Annie Brydon Lifecare provided an environment that supported residents' rights and culturally safe care. Staff demonstrated an understanding of residents' rights and obligations. There were health plans that encapsulated care specifically directed at Māori and Pacific peoples.

The service worked collaboratively with internal and external Māori supports to encourage a Māori world view of health in service delivery. Māori were provided with equitable and effective services based on Te Tiriti o Waitangi and the principles of mana motuhake (self-determination), and this was confirmed by Māori residents and staff interviewed.

Systems processes and support were in place to enable Pacific peoples to be provided with services that recognised their worldviews in a culturally safe manner.

Residents and their whānau were informed of their rights according to the Health and Disability Services Consumers' Rights (the Code), and these were upheld. Residents were safe from abuse and were receiving services in a manner that respected dignity, privacy and independence. Care plans reviewed accommodated the choices of residents and/or their whānau. There was evidence that residents and their whānau were kept well informed.

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

Complaints were resolved promptly and effectively in collaboration with all parties involved. There were processes in place to ensure that the complaints process works equitably for Māori. Complaints were fully documented, with corrective actions in place where these were required.

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.		Subsections applicable to this service fully attained.

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

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

The quality and risk management systems were focused on improving service delivery and care. Residents and whānau provided regular feedback and staff engaged in quality activities. An integrated approach included collection and analysis of quality improvement data, identifying trends that led to improvements. Actual and potential risks were identified and mitigated.

Adverse events were documented, with corrective actions implemented. The service complied with statutory and regulatory reporting obligations.

Staff were appointed, orientated and managed using current good practice. Staffing was sufficient to provide clinically and culturally appropriate care. A systematic approach to identify and deliver ongoing learning supported safe and equitable service delivery.

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

Ngā huarahi ki te oranga | Pathways to wellbeing

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

When residents were admitted to Annie Brydon Lifecare, a person-centred and whānau-centred approach was adopted. Relevant information was provided to the potential resident and their whānau.

The service worked in partnership with the residents and their whānau to assess, plan and evaluate care. Care plans were individualised.

Residents were supported to maintain and develop their interests and participate in meaningful community and social activities suitable to their age and stage of life.

Medicines were safely managed and administered by staff who had been assessed as competent to do so.

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

Residents were transitioned or transferred to other health facilities as required.

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

Includes two subsections that support an outcome where Health and disability services are provided in a safe environment appropriate to the age and needs of the people receiving services that facilitates independence and meets the needs of people with disabilities.		Subsections applicable to this service fully attained.

The facility met the needs of residents and was clean and well maintained. There was a current building warrant of fitness. Electrical and biomedical equipment had been checked and tested as required. External areas were accessible, safe, provided shade and seating, and met the accessibility needs of tāngata whaikaha.

Staff had been trained in emergency procedures, the use of emergency equipment and supplies, and attended regular fire drills. Staff, residents and whānau interviewed understood emergency and security arrangements. Security was maintained.

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

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

Heritage Lifecare Limited and the senior care team at Annie Brydon Lifecare ensured the safety of residents and staff through planned infection prevention and antimicrobial stewardship programmes that were appropriate to the size and complexity of the service and linked to the quality system.

The programmes were adequately resourced; an experienced and trained infection prevention nurse led the programme and engaged in procurement processes. Annual reviews of the programmes were reported to the Heritage Lifecare Board Of Directors, as were any significant infection events.

Aged care-specific infection surveillance was undertaken.

The environment supported both the prevention of infections and mitigation of their transmission. Waste and hazardous substances were managed. There were safe and effective cleaning and laundry services in place.

Here taratahi | Restraint and seclusion

Includes four subsections that support outcomes where Services shall aim for a restraint and seclusion free environment, in which people's dignity and mana are maintained.		Subsections applicable to this service fully attained.

The service was a restraint-free environment. This was supported by the governing body and policies and procedures. There were no residents observed to be using a restraint at the time of audit. A comprehensive assessment, approval and monitoring process, with regular reviews, is in place should restraint use be required in the future.

A suitably qualified restraint coordinator, who is a registered nurse, manages the process. Staff interviewed demonstrated a sound knowledge and understanding of providing least restrictive practice, de-escalation techniques, alternative interventions to restraint, and restraint monitoring.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Subsection	0	27	0	0	0	0	0
Criteria	2	166	0	0	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	Heritage Lifecare Limited (HLL) had a Māori Health Plan which guided care delivery for Māori using Te Whare Tapa Whā model, and by ensuring mana motuhake (self-determination) was being respected. The plan had been developed with input from cultural advisers and was in use for residents who identify as Māori at Annie Brydon Lifecare (Annie Brydon). Input from Māori was being supported through the Māori Network Komiti, a group of Māori employees. The Komiti has a mandate to further assist the organisation in relation to its response to the Ngā Paerewa Health and Disability Services Standard NZS 8134:2021, and its Te Tiriti o Waitangi obligations. The Māori Network Komiti has a kaupapa Māori structure and involves people from the clinical leadership group, clinical service managers, site managers, registered nurses (RNs), and other care workers. The group provides information through the clinical governance structure (the clinical advisory group) to the board. The service can access support through Te Whatu Ora – Health New Zealand (Te Whatu Ora), through local Māori health providers, and through its local iwi, Ngāti Ruanui. The staff recruitment policy was clear that recruitment would be non-discriminatory, and that cultural fit was one aspect of appointing staff.

		The service supports increasing Māori capacity by employing more Māori staff members across differing levels of the organisation, and this is outlined in its strategic plan and in policy documentation. Ethnicity data was being gathered when staff were employed, and this data was analysed at a management level. Staff who identified as Māori were employed at all levels of the organisation, including in leadership and training roles. Training on Te Tiriti o Waitangi, cultural safety, health equity and tikanga Māori was part of the HLL training programme, and this had been implemented in the service. The training was designed to assist staff to understand the key elements of service provision for Māori and tāngata whaikaha, ensuring culturally appropriate services, respect for mana motuhake, and the provision of equity in care services.
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	HLL understands the equity issues faced by Pacific peoples and can access guidance from people within the organisation around appropriate care and service for people from Pacific communities. There were members of the executive team who identified as Pacific people. They can assist the board to meet its equity obligations to residents from Pacific communities. A Pacific peoples' health plan and culturally safe care policy and procedure have been developed, with input from cultural advisers. These plans document care requirements for Pacific peoples to ensure culturally appropriate services can be delivered. The Fonofale model of care was available for use by the service for residents from Pacific communities who might be admitted. Annie Brydon has access to local Pacific communities through Vaimoana Pasifika and Te Whatu Ora. The staff recruitment policy was clear that recruitment would be non-discriminatory, and that cultural fit was one aspect of appointing staff. The service supports increasing capacity by employing more staff members who align with Pacific communities across differing levels of the organisation. This is outlined in its strategic plan, and in policy documentation. Ethnicity data was gathered when staff were employed, and this data was being analysed at a management level. There were staff who identified with a Pacific community in the service, but no residents. Training on culturally and spiritually specific care needs for

		people from Pacific communities was part of the HLL training programme, and this has been delivered. The training was geared to assist staff to understand the key elements of service provision for Pacific peoples, and in providing equity in the provision of care services.
Subsection 1.3: My rights during service delivery The People: My rights have meaningful effect through the actions and behaviours of others. Te Tiriti:Service providers recognise Māori mana motuhake (self-determination). As service providers: We provide services and support to people in a way that upholds their rights and complies with legal requirements.	FA	Staff interviewed understood the requirements of the Code of Health and Disability Services Consumers' Rights (the Code) and were observed supporting residents in accordance with their wishes. The Code was available in te reo Māori, English, and New Zealand Sign Language (NZSL). Residents and whānau interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service), and were provided with opportunities to discuss and clarify their rights. Staff training on the Code had been conducted. The service worked collaboratively with internal and external Māori supports to encourage the Māori view of health in service delivery. Māori were provided with equitable and effective services based on Te Tiriti o Waitangi and the principles of mana motuhake, and this was confirmed by Māori residents, whānau and staff interviewed. There was a health plan in place that was specifically directed at Māori. Staff have access to a culturally appropriate model of care to guide culturally safe service delivery. The use of this model was evident in the care plans of Māori residents within the service. The service can access support through local Māori health providers and through its local iwi.
Subsection 1.4: I am treated with respect The People: I can be who I am when I am treated with dignity and respect. Te Tiriti: Service providers commit to Māori mana motuhake. As service providers: We provide services and support to people in a way that is inclusive and respects their identity and their experiences.	FA	Annie Brydon supported residents in a manner that was inclusive and respected their identity and experiences. Residents and their whānau, including tāngata whaikaha, confirmed that they received services in a manner that had regard for their dignity, gender, privacy, sexual orientation, spirituality, choices, and independence. Care staff understood Te Tiriti o Waitangi and cultural safety. Tikanga Māori was promoted. All staff working at Annie Brydon were educated in Te Tiriti Waitangi

		and cultural safety. The staff could speak and learn te reo Māori, with the assistance of staff members and residents who identified as Māori. Two care plans reviewed related to residents who identified as Māori; the plans acknowledged the residents' cultural identity and individuality. Residents were assisted to have an advanced care plan in place. Staff were aware of how to act on residents' advance directives. Residents interviewed verified they were supported to do what was important to them, and this was also observed during audit. Staff were observed to maintain residents' privacy. All residents had a private room. Annie Brydon responded to tāngata whaikaha needs and enabled their participation in te ao Māori.
Subsection 1.5: I am protected from abuse The People: I feel safe and protected from abuse. Te Tiriti: Service providers provide culturally and clinically safe services for Māori, so they feel safe and are protected from abuse. As service providers: We ensure the people using our services are safe and protected from abuse.	FA	Employment practices at Annie Brydon included reference checking and police vetting. Policies and procedures outlined safeguards in place to protect people from discrimination; coercion; harassment; physical, sexual, or other exploitation; abuse; or neglect. Workers followed a staff code of conduct. Training had been undertaken on abuse and neglect for all staff within the past 12 months. Staff understood the service's policy on abuse and neglect, including what to do should there be any signs of such practice. Policies and procedures were in place that focused on zero tolerance to institutional and systemic racism, and there was a willingness by staff to address racism and act on it. Residents reported that their property was respected, and finances protected. Professional boundaries were maintained. A strengths-based and holistic model of care was evident, which included the use of Te Whare Tapa Whā model for Māori. This was verified in the care plans reviewed. Eight residents and six whānau interviewed expressed satisfaction with the care provided at Annie Brydon.
Subsection 1.6: Effective communication occurs The people: I feel listened to and that what I say is valued, and I	FA	Residents and their whānau at Annie Brydon reported that communication was open and effective, and they felt listened to.

feel that all information exchanged contributes to enhancing my wellbeing. Te Tiriti: Services are easy to access and navigate and give clear and relevant health messages to Māori. As service providers: We listen and respect the voices of the people who use our services and effectively communicate with them about their choices.		Information was provided in an easy-to-understand format, in English and te reo Māori. Te reo Māori was incorporated on signage within the facility and in some organisational documentation (e.g., in care plans and complaints, and infection control documentation). Interpreter services were available if needed, and staff knew how to access these services if required. Resident and whānau meetings were held regularly, in addition to regular contacts with whānau by email, telephone, and an open-door policy by the care home and village manager (CHVM) and the clinical service manager (CSM). An independent advocate holds meetings with residents at defined intervals; they would report any concerns back the CHVM. Informal notes taken from the meeting by the independent advocate documented that no concerns had been expressed. A notification on the notice boards advised when the next resident and whānau and independent advocate meetings were scheduled. Evidence was sighted of residents communicating with all staff, including the CHVM and CSM. Residents and their whānau, and staff, reported the CHVM and CSM responded promptly to any suggestions or concerns. Changes to residents' health status were communicated to residents and their whānau in a timely manner. Incident reports evidenced whānau were informed of any events/incidents. Documentation supported evidence of ongoing contact with whānau or the residents' enduring powers of attorney (EPOA). Evidence was sighted of referrals and involvement of other agencies involved in the residents' care when needed.
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	FA	Residents at Annie Brydon and/or their legal representatives were provided with the information necessary to make informed decisions. They felt empowered to actively participate in decision-making. The clinical team, when interviewed, understood the principles and practice of informed consent, supported by policies in accordance with the Code and in line with tikanga guidelines. Organisational policies on informed consent were in place. Staff who identified as Māori assisted other staff to support cultural

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.		practice. Evidence was sighted of supported decision-making, being fully informed, the opportunity to choose, and cultural support provided when a resident had a choice of treatment options available to them. Advance care planning, establishing and documenting of EPOA requirements and processes for residents unable to consent were documented, as relevant, in the resident's record.
Subsection 1.8: I have the right to complain The people: I feel it is easy to make a complaint. When I complain I am taken seriously and receive a timely response. Te Tiriti: Māori and whānau are at the centre of the health and disability system, as active partners in improving the system and their care and support. As service providers: We have a fair, transparent, and equitable system in place to easily receive and resolve or escalate complaints in a manner that leads to quality improvement.	FA	A fair, transparent and equitable system was in place to receive and resolve complaints that leads to improvements. This meets the requirements of the Code. Information on complaints and the complaints process was available in English and te reo Māori. Residents and whānau interviewed understood their right to make a complaint and knew how to do so. There have been six complaints received in the last 12 months. All complaints, formal and informal, were managed as per the HLL complaints process. Documentation sighted in respect of the complaints showed that all complaints had been responded to within appropriate timeframes and that the complainants had been informed of findings and any corrective action arising from the complaint following investigation. There have been no complaints from Māori in the service, but there were processes in place to ensure complaints from Māori could be managed in a culturally appropriate way (e.g., using culturally appropriate support, hui, and tikanga practices specific to the resident or the complainant). There was one (historic) complaint received in 2022 via the Health and Disability Commissioner (HDC) Advocacy Service, which was later referred to the HDC. The complaint related to the standard of care delivered to a resident. While the complaint remained open, the service had responded to the HDC within appropriate timeframes. No complaints have been received from any other external sources.
Subsection 2.1: Governance	FA	The governing body assumes accountability for delivering a high-

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.		quality service through supporting meaningful inclusion of Māori and Pacific peoples in governance groups, honouring Te Tiriti, and being focused on improving outcomes for Māori residents, those from a Pacific community, and tāngata whaikaha. HLL has a legal team who monitor changes to legislative and clinical requirements and have access to domestic and international legal advice. Directors of HLL have undertaken the e-learning education on Te Tiriti, health equity, and cultural safety provided by Manatū Hauora. Input from Māori into board activities was through the Māori Network Komiti, which is made up of a group of Māori staff in the service. Information garnered from these sources translates into policy and procedure. Equity for Māori, Pacific peoples, and tāngata whaikaha was addressed through policy documentation and enabled through choice and control over supports and the removal of barriers that prevent access to information (e.g., information in other languages for the Code of Rights, complaints, and infection prevention and control). HLL utilise the skills of staff and senior managers and supports them in making sure barriers to equitable service delivery can be surmounted. HLL has a strategic plan in place which outlines the organisation's structure, purpose, values, scope, direction, performance, and goals. Ethnicity data was being collected to support equity; a process was in place to analyse and utilise the data to support meaningful change. Governance and the senior leadership team commit to quality and risk via policy and processes, and through feedback mechanisms. This includes receiving regular information from each of its care facilities. The HLL reporting structure relies on information from its strategic plan to inform facility-based business plans. Annie Brydon has its own business plan for its services. Internal data collection (e.g., adverse events, complaints, and internal audits) was aggregated, and corrective action (at facility and organisation level as applicable) actioned. Feedback was through the clinical advisory group to the board. Changes were made to business and/or the strategic plans, and policies and procedures as required; documentation to support this was sighted. Position descriptions were in place for all positions, including specialist positions such as infection control and restraint. These specify the

		requirements for the position and key performance indicators (KPIs) to assess performance. Recruiting and retaining people is a focus for HLL. The organisation looks for the 'right people in the right place' and aims to keep them in place for a longer period to promote stability. It also uses feedback from cultural advisers, including the Māori Network Komiti, to inform workforce planning, sensitive and appropriate collection and use of ethnicity data, and how it can support its ethnically diverse staff. The clinical governance structure in place was appropriate to the size and complexity of the service provision. The CHVM has been in the service for four years and the CSM for two and a half years, having been qualified as a RN since 1993. Both the CHVM and the CSM are experienced in the aged care sector and confirmed knowledge of the sector and regulatory and reporting requirements, and both maintain currency within the field. The CSM is supported by nine other RNs, eight of whom were interRAI certified. HLL supports people to participate through care planning activities, resident/whānau and independent advocate meetings, satisfaction surveys, and through the complaints process. There was also a staff satisfaction survey for a wider view of how residents and staff are being supported. Results from both surveys were highly positive. The service holds contracts with Te Whatu Ora for age-related residential care (ARRC) services at rest home- and hospital-level, long-term support – chronic health conditions (LTS-CHC), and short-term care (respite). It also holds an individual Disability Support Service (DSS) contract (at rest home-level care) from the Ministry of Social Development/Te Manatū Whakahiato Ora, and a contract with the Accident Compensation Corporation (ACC). Sixty-three (63) residents were receiving services at the time of audit. Forty-one (41) residents were receiving rest home-level care (including one under an LTS-CHC contract and one under a DSS contract) and 22 hospital-level care (including one under an LTS-CHC contract and one through ACC). No residents were receiving care under the respite contract.

Subsection 2.2: Quality and risk The people: I trust there are systems in place that keep me safe, are responsive, and are focused on improving my experience and outcomes of care. Te Tiriti: Service providers allocate appropriate resources to specifically address continuous quality improvement with a focus on achieving Māori health equity. As service providers: We have effective and organisation-wide governance systems in place relating to continuous quality improvement that take a risk-based approach, and these systems meet the needs of people using the services and our health care and support workers.	FA	The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes the management of incidents/accidents/hazards (including the monitoring of clinical incidents such as falls, pressure injuries, infections, wounds, and medication errors), complaints, audit activities, and policies and procedures. Relevant corrective actions were developed and implemented to address any shortfalls. Progress against quality outcomes was evaluated and documented. Quality data was communicated and discussed, and this was confirmed by staff at interview and in meeting minutes. The CHVM and CSM understood the processes for the identification, documentation, monitoring, review, and reporting of risks, including health and safety risks, and development of mitigation strategies. Policies reviewed covered all necessary aspects of the service and contractual requirements, and were current. Critical analysis of organisational practices to improve health equity has been occurring across the organisation, including at Annie Brydon. A Māori health plan guides care for Māori. Staff have received education in relation to the care of Māori, residents from Pacific communities, and tāngata whaikaha. Residents and staff contribute to quality improvement through the opportunity to provide feedback at meetings and in surveys. Residents have meetings facilitated by an independent advocate, who takes the meeting reporting back to the CHVM anonymously (unless permission to name has been granted) of any concerns. No concerns had been raised in the last two meetings, according to meeting notes sighted. Residents' meeting minutes and the resident satisfaction surveys showed a high level of satisfaction with the services provided. Residents and whānau interviewed also reported high satisfaction levels. Staff document adverse and near-miss events in line with the National Adverse Events Reporting Policy. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed, and any corrective actions followed up in a timely manner. The CHVM and CSM both understood and have complied with

		essential notification reporting requirements. In the last 12 months there have been six Section 31 notifications made to HealthCert (at Manatū Hauora) related to power (two), a heating outage, an unexpected fire alarm, and related to resident care or management (two). There have been six notifications to the Health Safety & Quality Commission (HSQC) related to pressure injury (two), a head injury following a fall, and fracture following falls (three).
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 was a documented and implemented process for determining staffing levels and skill mixes to provide culturally and clinically safe care, 24 hours a day, seven days a week (24/7). The service is being managed by the CHVM, who is experienced in aged care and has worked at the facility for four years. The CHVM is supported by an experienced RN who works as the CSM and who has worked at the facility for two and a half years; both work Monday to Friday and share on-call. There were RNs on duty 24/7 and there was a first aid certified staff member on duty 24/7; this was confirmed on rosters sighted. The facility adjusted staffing levels to meet the changing needs of residents to align with HLL policy and could access support from casual staff to address any staff absence. Care staff interviewed reported there were adequate staff to complete the work allocated to them. Residents and whānau interviewed reported prompt attention from staff. Position descriptions reflected the role of the position and expected behaviours and values. Descriptions of roles cover responsibilities and additional functions, such as holding an infection prevention and control or restraint portfolio. Continuing education was planned on an annual basis and included mandatory training requirements. Related competencies had been assessed and supported equitable service delivery. Records reviewed demonstrated completion of the required training and competency assessment programmes. Care staff had access to a New Zealand Qualifications Authority education programme to meet the requirements of the provider's agreements with Te Whatu Ora. The collection and sharing of high-quality health information across the

		service, including for Māori and Pacific peoples, is through policy and procedure, appropriate care planning using relevant models of care, resident and whānau engagement, and through staff competency assessment and education. Staff reported feeling well supported and safe in the workplace. There were policies and procedures in place around wellness, bullying, and harassment. An employee assistance programme (EAP) was available to staff who may require extra support.
Subsection 2.4: Health care and support workers The people: People providing my support have knowledge, skills, values, and attitudes that align with my needs. A diverse mix of people in adequate numbers meet my needs. Te Tiriti: Service providers actively recruit and retain a Māori health workforce and invest in building and maintaining their capacity and capability to deliver health care that meets the needs of Māori. As service providers: We have sufficient health care and support workers who are skilled and qualified to provide clinically and culturally safe, respectful, quality care and services.	FA	Human resources management policies and processes were based on good employment practice and relevant legislation and included recruitment, selection, orientation, and staff training and development. Qualifications were validated prior to employment and then annually; evidence of this was sighted. A register of annual practising certificates (APCs) had been maintained for RNs, and associated health contractors. There were job descriptions in place for all positions which included outcomes, accountability, responsibilities, authority, and functions to be achieved in each position. A sample of nine staff records reviewed evidenced implementation of the recruitment process, employment contracts, reference checking, police vetting, and completed induction and orientation. Staff interviewed confirmed that orientation does take place; they described it as useful in preparing them for their role, reporting that they felt ready to take on their role when orientation was completed. Files sampled evidenced that performance appraisals were being undertaken as required. Staff described the appraisal process as useful for them, they had input into them, and the process allowed them to set their own career and education goals. Ethnicity data was being recorded for staff and used in accordance with Health Information Standards Organisation (HISO) requirements. There were staff well-being policies in place and staff were aware of them. Staff interviewed confirmed that debrief and support was available to them following any serious incidents or challenging situations.

Subsection 2.5: Information The people: Service providers manage my information sensitively and in accordance with my wishes. Te Tiriti: Service providers collect, store, and use quality ethnicity data in order to achieve Māori health equity. As service provider: We ensure the collection, storage, and use of personal and health information of people using our services is accurate, sufficient, secure, accessible, and confidential.	FA	Annie Brydon maintained quality records that complied with relevant legislation, health information standards, and professional guidelines. Most resident and staff information was held electronically; this was username- and password-protected. Resident's files were integrated and mostly electronic, with some paper copy documents which were scanned into the resident's record (e.g., EPOAs). Access to resident and staff information was limited dependent on the role of the person in the service. Any paper-based records were held securely, only available to authorised users, and archived and destroyed within appropriate timeframes. Processes were in place to ensure information was readily retrievable. Data collected included ethnicity data of both residents and staff. All necessary demographic, personal, clinical, and health information was fully completed in the residents' files sampled for review. Clinical notes were current, integrated and legible, and met current documentation standards. Consent was sighted for data collection. The service is not responsible for National Health Index registration.
Subsection 3.1: Entry and declining entry The people: Service providers clearly communicate access, timeframes, and costs of accessing services, so that I can choose the most appropriate service provider to meet my needs. Te Tiriti: Service providers work proactively to eliminate inequities between Māori and non-Māori by ensuring fair access to quality care. As service providers: When people enter our service, we adopt a person-centred and whānau-centred approach to their care. We focus on their needs and goals and encourage input from whānau. Where we are unable to meet these needs, adequate information about the reasons for this decision is documented and communicated to the person and whānau.	FA	Residents were welcomed to Annie Brydon when they had been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) agency as requiring the level of care Annie Brydon provided, and had chosen Annie Brydon to provide the services they required. Annie Brydon had recently focused on the admission process for residents, implementing a pre-admission process to acclimate residents to the service prior to their admission. The reason for this was to reduce the stress on residents and whānau when they entered the service, and to make sure the staff knew something about the residents prior to admission. The process goes beyond the requirements of the service, and a continuous improvement rating was applied (refer criterion 3.1.1). Whānau interviewed stated they were satisfied with the admission process and the information that had been made available to them on

		admission, including for residents who identified as Māori. The files reviewed met contractual requirements. Annie Brydon routinely collected and analysed entry and decline rates for residents and prospective residents. This included specific data on entry and decline rates for Māori. Where a prospective resident had been declined entry, there were processes for communicating the decision to the person and/or whānau. Annie Brydon had developed meaningful partnerships with local Māori to benefit Māori individuals and their whānau. The facility can access support from Māori health practitioners, traditional healers, and other organisations by contacting the local Māori cultural provider. When admitted, residents had a choice over who would provide the oversight of their medical requirements. Whilst most chose the nurse practitioner at Annie Brydon, residents can choose another provider to oversee their medical needs.
Subsection 3.2: My pathway to wellbeing The people: I work together with my service providers so they know what matters to me, and we can decide what best supports my wellbeing. Te Tiriti: Service providers work in partnership with Māori and whānau, and support their aspirations, mana motuhake, and whānau rangatiratanga. As service providers: We work in partnership with people and whānau to support wellbeing.	FA	The team at Annie Brydon worked in partnership with the resident and their whānau to support the resident's wellbeing. Eight residents' files were reviewed, four for residents receiving hospital care, and four rest home care. These files included residents who identified as Māori, residents who had experienced an acute event requiring transfer to an acute facility, residents with a wound, residents with behaviours that challenge, residents who had had a fall, and residents with complex comorbidities. The eight files reviewed verified that a care plan had been developed by a RN following a comprehensive assessment, including consideration of the person's lived experience, cultural needs, values, and beliefs, with consideration of wider service integration, where required. Assessments were based on a range of clinical assessments and included the resident and whānau input (as applicable). Timeframes for the initial assessment, general practitioner (GP)/nurse practitioner (NP) input, initial care plan, interRAI assessment, long-term care plan, short-term care plans, and review/evaluation timeframes met contractual requirements. Residents who had had an unwitnessed fall

		had an incident form completed, with neurological observations taken with oversight by the RN, and notification to the resident's family. Residents with long-standing wounds had wound assessments, a wound management plan, and documentation that verified treatment was provided in accordance with the plan and best practice guidelines. Input from the wound care nurse had been sought and their advice included in the treatment regime. Behaviours that challenged had been managed in accordance with the documented behaviour management plan. Short-term care plans were evident in five of the files reviewed. Short-term problems had been identified, as well as interventions to address the problems. Evaluations had been completed. Ongoing unresolved problems were transferred to the long-term plan for ongoing clinical management. Of note, a new initiative was being used by Annie Brydon related to a protocol that acknowledges the end-of-life journey with arohanui and tikanga. This project was planned to show a visible, respectful protocol that acknowledges and respects the needs of the dying resident and their whānau, and as such was awarded a continuous improvement rating (refer criterion 3.2.2). Policies and processes were in place to ensure tāngata whaikaha and whānau participated in Annie Brydon's service development and delivery of services that provided choice and control, removing barriers that prevented access to information. Service providers understood the Māori constructs of oranga and had implemented a process to support Māori and whānau to identify their pae ora outcomes in their care plans. The support required to achieve this was documented, communicated, and understood. This was verified by reviewing documentation, sampling residents' records, interviews with residents, whānau and staff, and from observation. Management of any specific medical conditions was well documented, with evidence of systematic monitoring and regular evaluation of responses to planned care. Where progress was different from that expected, changes were made to the care plan in collaboration with the resident and/or whānau. Residents and whānau confirmed active involvement in the process, including residents with a disability. Interviews with six whānau of other residents expressed a high degree of satisfaction with the care provided at Annie Brydon. The residents

		and their whānau were actively involved in planning the residents' care and any ongoing discussions. Interviews with the staff identified that they were familiar with all aspects of the care provided to residents. An interview with the NP expressed satisfaction with the care provided by the team at Annie Brydon. The physiotherapist was also contacted and expressed satisfaction with follow-up interventions for residents at Annie Brydon.
Subsection 3.3: Individualised activities The people: I participate in what matters to me in a way that I like. Te Tiriti: Service providers support Māori community initiatives and activities that promote whanaungatanga. As service providers: We support the people using our services to maintain and develop their interests and participate in meaningful community and social activities, planned and unplanned, which are suitable for their age and stage and are satisfying to them.	FA	Two activities assistants provide an activities programme at Annie Brydon seven days a week. One activities assistant was enrolled in a New Zealand Qualifications Authority (NZQA) diversional therapy specific course. The programme supports residents to maintain and develop their interests and was suitable for their ages and stages of life. Activity assessments and plans identified individual interests and considered the person's identity. Individual and group activities reflected residents' goals, interests and ordinary patterns of life, and included normal community activities. Younger residents were enabled to attend community activities of their choice as desired and participate in activities that were of interest to them. Opportunities for Māori and whānau to participate in te ao Māori, including tikanga, were facilitated. Different community groups visit the facility, including an early childhood group from the local iwi and the Kōhanga Reo. Matariki and Waitangi Day have been celebrated with food, language, and cultural activities. Annie Brydon provides a 24/7 approach to activities, offering activities and diversion at appropriate times for residents, in line with the individual needs identified in the care plan. Residents and whānau were involved in evaluating and improving the programme. A satisfaction survey evidenced that residents and their whānau were very satisfied with the activities provided at Annie Brydon. Residents, whānau and staff interviewed reported that they find the individual and group programmes meet the needs of residents

		at Annie Brydon.
Subsection 3.4: My medication The people: I receive my medication and blood products in a safe and timely manner. Te Tiriti: Service providers shall support and advocate for Māori to access appropriate medication and blood products. As service providers: We ensure people receive their medication and blood products in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	The medication management policy was current and in line with the Medicines Care Guide for Residential Aged Care and current best practice. A safe system for medicine management (using an electronic system) was observed on the day of audit. Sixteen files were reviewed. There was a process in place to identify, record and document residents' medication allergies and sensitivities, and the action required for adverse events. Staff who administer medicines had been assessed annually as competent to perform the function they manage. All staff administering medication had completed the required assessments. Medications were being supplied to the facility in a pre-packaged format from a contracted pharmacy. Medication reconciliation occurred. All medications sighted were within current use-by dates. Over-the-counter medication and supplements were considered by the prescriber as part of the person's medication. Medicines were stored safely, including controlled drugs. Controlled drugs were stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries. Medicines stored were within the recommended temperature range, and records were maintained and were reviewed. A system was in place for returning expired or unwanted medication to the contracted pharmacy. Prescribing practices met requirements. The required three-monthly NP/GP review was consistently recorded on the medicine chart. Standing orders were not in use at Annie Brydon. Self-administration of medication was facilitated and managed safely. Residents, including Māori residents and their whānau, had been supported to understand their medications.

Subsection 3.5: Nutrition to support wellbeing The people: Service providers meet my nutritional needs and consider my food preferences. Te Tiriti: Menu development respects and supports cultural beliefs, values, and protocols around food and access to traditional foods. As service providers: We ensure people's nutrition and hydration needs are met to promote and maintain their health and wellbeing.	FA	The food service was in line with recognised nutritional guidelines for older people. The menu was reviewed on 23 April 2025 by a qualified dietitian. All recommendations made have been incorporated into the menu and signed off by the dietitian. All aspects of food management comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by South Taranaki District Council. The food control programme period of certification extends from 24 February 2025 through to 23 February 2026. Residents who wish to be involved in the preparation of food have this facilitated through the activities programme. Each resident has a nutritional assessment on admission to the facility. Personal food preferences, food sensitivities, any special diets and modified texture requirements were accommodated in the daily meal plan. Menu options were available for other cultures, including te ao Māori. Evidence of resident satisfaction with meals was verified by resident and whānau interviews, through meal satisfaction surveys and resident meeting minutes. A resident satisfaction survey completed in 2025 evidenced residents and their whānau were generally satisfied with the food services provided at Annie Brydon. Meal satisfaction audits had been completed quarterly, and results from those audits were noted to be positive. Residents could choose their time preferences to eat their meals. Residents were also given sufficient time to eat their meals. Assistance and monitoring were provided to residents who required this.
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.	FA	Transfer or discharge from the service was planned and managed safely, with coordination between services and in collaboration with the resident and whānau. This was evident in the file of the resident audited using tracer methodology who required transfer to an acute care facility. The RN's regular contact with whānau was well documented. Resident transfer documentation was noted to be comprehensive, with

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.		a full and accurate account of the event in the resident's file. Prior to transfer of the resident back to Annie Brydon, the RN engaged with the hospital to ensure all relevant information for ongoing care of the resident was communicated and documented. The resident and whānau interviewed reported being kept well informed and supported by staff during the recent transfer to the acute facility. Whānau were advised of their options to access other health and disability services, social support, or kaupapa Māori services if the need is identified.
Subsection 4.1: The facility The people: I feel the environment is designed in a way that is safe and is sensitive to my needs. I am able to enter, exit, and move around the environment freely and safely. Te Tiriti: The environment and setting are designed to be Māori-centred and culturally safe for Māori and whānau. As service providers: Our physical environment is safe, well maintained, tidy, and comfortable and accessible, and the people we deliver services to can move independently and freely throughout. The physical environment optimises people's sense of belonging, independence, interaction, and function.	FA	Appropriate systems were in place to ensure the residents' physical environment and facilities (internal and external) were fit for their purpose, well maintained, and that they meet legislative requirements. A planned maintenance schedule included electrical testing and tagging, resident equipment checks, and checking and calibration of clinical equipment. Monthly hot water tests were completed for resident areas; these were sighted. Tempering valves were in place to manage the occasional hot water variance. The building had a building warrant of fitness with an expiry date of 15 October 2025. There were currently no plans for further building projects requiring consultation, but HLL directors were aware of the requirement to consult with Māori if this was envisaged. The environment was comfortable and accessible. Corridors have handrails promoting independence and safe mobility. Personalised equipment was available for residents with disabilities to meet their needs, and residents were observed to be safely using these. Spaces were culturally inclusive and suited the needs of the resident groups, including smaller private spaces for residents and tāngata whaikaha who might want quiet time or privacy. Lounge and dining facilities met the needs of residents, and these were also used for activities. There were adequate numbers of accessible bathroom and toilet facilities throughout the facility, including for staff and visitors. All rooms, bathrooms and common areas have appropriately situated call bells. There were external areas within the facility for leisure activities with

		appropriate seating and shade. Residents' rooms were spacious and allowed room for the use of mobility aids and moving and handling equipment if required. Twenty-four (24) of the rooms were being offered under Occupation Right Agreements (ORAs) and five were certified for double occupancy. One room (from the five) was double occupied by a couple at the time of audit. Rooms were personalised according to the resident's preference. All rooms have a window allowing for natural light, with safety catches for security. Electric heating was being provided in the facility, which can be adjusted depending on seasonality and outside temperature. Space was available for the storage and charging of electronic mobility aids. Residents and whānau interviewed were happy with the environment, including heating and ventilation, privacy, and maintenance. Care staff interviewed stated they have adequate equipment to safely deliver care for residents.
Subsection 4.2: Security of people and workforce The people: I trust that if there is an emergency, my service provider will ensure I am safe. Te Tiriti: Service providers provide quality information on emergency and security arrangements to Māori and whānau. As service providers: We deliver care and support in a planned and safe way, including during an emergency or unexpected event.	FA	The fire evacuation plan was approved by Fire and Emergency New Zealand (FENZ) on 19 July 1998 (confirmed in a letter from FENZ dated 13 July 2013). The requirements of the fire and emergency scheme were reflected in the facility's fire and emergency management plan, which requires a six-monthly fire drill; the last fire drill was held on 21 August 2025. Fire and emergency education and competency were required as part of the orientation process and through ongoing education. Ongoing education and competency assessment had been delivered to staff in 2025; staff interviewed were able to describe what they would do in an emergency. Disaster and civil defence plans and policies direct the facility in its preparation for disasters and described the procedures to be followed. Staff have received relevant information and training and have appropriate equipment to respond to emergency and security situations. Adequate supplies for use in the event of a civil defence emergency meet The National Emergency Management Agency recommendations for the region, and alternative essential energy and utility sources are available in the event of the main supplies failing.

		The facility holds 1000 litres of water on site and sufficient food was stored for emergency use. The facility is currently undergoing a capital expenditure (CAPEX) process to buy a generator for the site. In the interim, there is an agreement for a generator to be provided from a local supplier. Following a recent power outage, the generator had been delivered to the site within an hour. Information on emergency and security arrangements was being provided to residents and their whānau on entry to the service. Information on fire and emergency protocols was available throughout the facility. Twenty (20) staff have current first aid certification and there was a first aid certified staff member on duty 24/7 on the rosters sighted. Call bells alert staff to residents requiring assistance. Residents and whānau reported staff respond promptly to call bells. Appropriate security arrangements were in place. The facility had overnight 'lock-up' procedures which allow for emergency egress, and a doorbell was in place for visitors to use. Staff were noted to be wearing uniforms and name badges throughout the audit.
Subsection 5.1: Governance The people: I trust the service provider shows competent leadership to manage my risk of infection and use antimicrobials appropriately. Te Tiriti: Monitoring of equity for Māori is an important component of IP and AMS programme governance. As service providers: Our governance is accountable for ensuring the IP and AMS needs of our service are being met, and we participate in national and regional IP and AMS programmes and respond to relevant issues of national and regional concern.	FA	Heritage Lifecare Limited has infection prevention (IP) and antimicrobial stewardship (AMS) outlined in its policy documents. The IP and AMS programmes were appropriate to the size and complexity of the service. They have been approved by the governing body, were linked to the quality improvement system, and were being reviewed and reported on annually. The IP and AMS programme was being supported at governance level through clinically competent specialist personnel who make sure that IP and AMS are being appropriately managed at facility level, and to support facilities as required. Clinical staff can access IP and AMS expertise and support though the HLL support office clinical specialist staff, and specialists through Te Whatu Ora (including nurse specialists, district nurses, and infection prevention and control nurse specialists). Advice can also be sought from Regional Public Health. Infection prevention and AMS information was being discussed at

		facility level and at clinical advisory group meetings, and was reported to the board. Information presented to the board includes ethnicity data to support equity in the IP and AMS programmes.
Subsection 5.2: The infection prevention programme and implementation The people: I trust my provider is committed to implementing policies, systems, and processes to manage my risk of infection. Te Tiriti: The infection prevention programme is culturally safe. Communication about the programme is easy to access and navigate and messages are clear and relevant. As service providers: We develop and implement an infection prevention programme that is appropriate to the needs, size, and scope of our services.	FA	The infection prevention and control coordinator (IPCC) was responsible for overseeing and implementing the IP programme, with reporting lines to the CSM and CHVM. The IPCC has the appropriate skills, knowledge and qualifications for the role and confirmed access to the necessary resources and support from the HLL clinical quality manager (CQM), Te Whatu Ora IP clinical nurse specialist, and/or regional public health. The infection prevention and control policies reflected the requirements of the Ngā Paerewa standard and were based on current accepted good practice. These policies were developed by HLL with input from IP specialists. Cultural advice was accessed by the HLL CQM who developed the infection control policies and programme The CHVM and CSM were aware of the need to consult with infection prevention personnel in relation to the proposed design of any new building or when significant changes were proposed to the existing facility. The advice of the IPCC had been sought when making decisions around procurement relevant to care delivery, and they can be consulted about new builds, facility changes, and policies. Staff at Annie Brydon were familiar with IPC policies through education during orientation and ongoing education, and were observed to follow policy and procedure correctly. Staff were familiar with policies for the decontamination of reusable medical devices, and there was evidence of these being appropriately decontaminated and reprocessed. Individual-use items were discarded after being used. Residents and whānau were educated about IP relevant to their needs. Staff who identify as Māori and speak te reo Māori can provide infection advice to residents and the IPCC in te reo Māori if needed for Māori accessing service. Local iwi and interpreter services can also be utilised to assist. There were educational resources available in te reo Māori for Māori accessing services.

		The pandemic/infectious diseases response plan was documented and had been tested. There were sufficient resources and personal protective equipment (PPE) available, stocks were sighted, and staff verified their availability at the interview. Staff had been trained in their use. Residents and their whānau were educated about infection prevention in a manner that met their needs.
Subsection 5.3: Antimicrobial stewardship (AMS) programme and implementation The people: I trust that my service provider is committed to responsible antimicrobial use. Te Tiriti: The antimicrobial stewardship programme is culturally safe and easy to access, and messages are clear and relevant. As service providers: We promote responsible antimicrobials prescribing and implement an AMS programme that is appropriate to the needs, size, and scope of our services.	FA	Responsible use of antimicrobials was being promoted. The AMS programme was appropriate for the size and complexity of the service, supported by policies and procedures that have been approved by the governing body. Responsible use of antimicrobials had been promoted that set out to optimise antimicrobial use and minimise harm in the service. The effectiveness of the AMS programme had been evaluated by monitoring antimicrobial use and identifying areas for improvement. Antimicrobial use was included in governance reporting. Evidence was sighted of a reduction in antibiotic use, and of antibiotics and antifungals only being used when appropriate.
Subsection 5.4: Surveillance of health care-associated infection (HAI) The people: My health and progress are monitored as part of the surveillance programme. Te Tiriti: Surveillance is culturally safe and monitored by ethnicity. As service providers: We carry out surveillance of HAIs and multi-drug-resistant organisms in accordance with national and regional surveillance programmes, agreed objectives, priorities, and methods specified in the infection prevention programme, and with an equity focus.	FA	Surveillance of health care-associated infections (HAIs) was appropriate to that recommended for long-term care facilities and was in line with priorities defined in the infection control programme. The programme included standardised surveillance definitions, data collection and analysis that included ethnicity data. Monthly surveillance data had been collated and analysed to identify any trends, possible causative factors, and required interventions. A monthly surveillance programme report included a summary of surveillance activities and areas for improvement. The report had been shared with the HLL regional IP team, the CHVM, CSM, staff, residents, and whānau. Results of the surveillance programme were also reported to the HLL board. Clear, culturally safe processes for communication between service providers and those residents who developed or experienced a HAI were evidenced in file notes and in an interview with the RN. A surveillance summary report for a recent gastroenteritis outbreak was

		reviewed and demonstrated a thorough process for investigation and follow-up. The Regional Public Health Unit (RPH) and Te Whatu Ora were informed of the outbreak. Learnings from the event have now been incorporated into practice
Subsection 5.5: Environment The people: I trust health care and support workers to maintain a hygienic environment. My feedback is sought on cleanliness within the environment. Te Tiriti: Māori are assured that culturally safe and appropriate decisions are made in relation to infection prevention and environment. Communication about the environment is culturally safe and easily accessible. As service providers: We deliver services in a clean, hygienic environment that facilitates the prevention of infection and transmission of antimicrobialresistant organisms.	FA	A clean and hygienic environment at Annie Brydon supported the prevention of infection and mitigation of transmission of antimicrobial-resistant organisms. Suitable PPE was provided to those handling contaminated material, waste, and hazardous substances, and those who perform cleaning and laundering roles. Safe and secure storage areas were available, and staff had appropriate and adequate access, as required. Chemicals were labelled and stored safely within these areas, with a closed system in place. Sluice rooms were available for the disposal of soiled water/waste. Handwashing facilities and cleansing gel were available throughout the facility. Staff followed documented policies and processes for the management of waste and infectious and hazardous substances. Staff interviewed and observed demonstrated good knowledge of policies and processes for the management of waste and infectious and hazardous substances. Laundry and cleaning policy and procedures were in place. There was clear separation of the handling and storage of clean and dirty laundry. Laundry and cleaning processes were monitored for effectiveness via the internal audit programme. Staff involved had completed relevant training and were observed to carry out duties safely. Residents and whānau reported that the laundry was managed well, and the facility, communal and person spaces were being kept clean and tidy. This was confirmed through observation.
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.	FA	Heritage Lifecare is committed to a restraint-free environment in all its facilities. Annie Brydon was restraint-free, and no residents were observed to be using a restraint during the audit. Restraint has not been used in the facility since 2023.

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.		There were strategies in place to eliminate restraint, including an investment in processes and equipment to support the removal of restraint (e.g., use of intentional rounding (scheduled resident checks), use of high/low beds, and sensor equipment). The HLL board's clinical advisory group was responsible for the HLL restraint elimination strategy and for monitoring restraint use in the organisation. Documentation confirmed that restraint had been discussed at the clinical advisory group meetings and then reported to the board. Policies and procedures meet the requirements of the standard. The restraint coordinator (RC) is a defined role currently being undertaken by the CSM. They provide support and oversight should restraint be required in the future. There was a job description that outlines the role, and the RC has had specific education around restraint and its use. Restraint protocols were covered in the orientation programme of the facility and included in the education/training programme (which includes annual restraint competency). Staff have been trained in the least restrictive practice, safe restraint practice, alternative cultural-specific interventions, de-escalation techniques, and restraint monitoring in 2025. Restraint use was identified as part of the quality programme and reported at all levels of the organisation. The RC, in consultation with the multidisciplinary team, would be responsible for the approval of the use of restraint should this be required in the future; there were clear lines of accountability. For any decision to use or not use restraint, there was a process to involve the resident, their EPOA and/or whānau, and the multidisciplinary team (including the GP or NP) as part of the decision-making process. A restraint register was available on the electronic resident management system; the criteria on the restraint register contains enough information to provide an auditable record of restraint, should this be required. The RC undertakes review of all residents who may be at risk, in conjunction with the other RNs and the GP/NP. Documentation outlines strategies to be used to prevent restraint being required, and this was sighted. Review of restraint had been completed at clinical governance level; any changes to policies, guidelines, education, and processes were implemented if indicated. Given there was no restraint being used in the facility, subsections 6.2

		and 6.3 have not been audited.

Specific results for criterion where corrective actions are required

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

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

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

No data to display

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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 3.1.1 During the initial engagement prior to service entry, service providers shall ensure: (a) There is accurate information about the service available in a variety of accessible formats; (b) There are documented entry criteria that are clearly communicated to people, whānau, and, where appropriate, local communities and referral agencies.	CI	Annie Brydon has been focused on the admission process for residents. It was noted that admission was a stressful time for residents and whānau as they entered a new space with new people, and that they were given a lot of information in a short period of time (including information related to consents). The service implemented a formal pre-admission process in June 2025 to acclimate residents to the service prior to their admission. The reason for this was to reduce the stress on residents and whānau when they entered the service, to make sure the staff knew something about the residents prior to admission, and to provide time for residents and their whānau to navigate the transition into care with confidence and ease. A PDCA cycle was used (Plan, Do, Check, Act). Pre-admission visits were focused on residents and whānau having time to connect with staff, understand processes, and complete essential paperwork away	Annie Brydon has introduced a pre-admission process that actively supports whanaungatanga. The process reduces the stress of moving into a new environment by introducing relaxed processes prior to the admission day to support the resident and their whānau as they move into the care environment. The process allows staff to know more about the resident, so that care can be individualised from the beginning. Residents and their whānau were being ‘buddied’ into the service by people who already live in the service. Residents have a key worker who is the first ‘go to’ person and who checks in on them regularly. The breadth and depth of this initiative exceeded that of full attainment of the criteria, and a continuous improvement rating was given.

		from the stress of moving into the care home. A resident ‘buddy’ system was implemented whereby another resident was ‘paired up’ with the incoming resident to assist with integration into the service. A key staff worker was also chosen for the resident to strengthen resident, whānau, and staff relationships, promoting a sense of belonging and connection and partnership (whanaungatanga). The ‘buddy’ system was well established. Numbers of available ‘buddies’ increased from seven in November 2024 to 23 people in September 2025. The ‘buddy’ welcomes the new resident and their whānau as part of the service and helps to orientate them to the new environment. Planning was implemented. This included: • Pre-admission support – the service developed documents (a pre-admission checklist and a pre-admission process explainer) with information aligned with assessments from the service’s electronic resident management system. These were provided to residents and their whānau prior to admission. • Meetings were held between the resident, their whānau, and the CHVM and administration staff prior to admission to build relationships and answer any questions in a comfortable, non-stressful environment. • A key worker was allocated to the incoming resident; it is their role to conduct regular welfare checks with the resident, and act as a liaison between the service and the resident’s whānau, for example, coordinating the purchase of any additional personal items the resident might require. • A resident buddy system was set up so that other residents (like in age and interest) would be able to help the new resident navigate the change to the care home environment.	

		• A ‘My Story’ was compiled to help the facility tailor its services to the individual’s history, preferences and interests, enabling the facility to better plan individualised care for the resident. Measurement of the success of the project was through: • Post-admission surveys of residents and/or their whānau developed around the five-step pre-admission process described above. Surveys are provided to residents and their whānau in hard copy and through electronic media to capture their experience. • The resident engagement survey – feedback was collected from residents on their experience, involvement in care, and satisfaction with services. • Compliments – positive feedback from residents and whānau was recorded as a qualitative measure of improved consumer experience. • Feedback from staff was also recorded as a qualitative measure of improved knowledge of the incoming resident and their family. Outcomes were: • Seven post-admission surveys completed by residents showing a high level of satisfaction with the process. • Compliments from three whānau whose loved ones had been admitted to the service, expressing appreciation for the smooth transition into the service. • The resident engagement survey showed a high level of satisfaction with the services being provided, recording a 4.5 (0-5 measure) in relation to ‘our environment’. • Feedback from the care home administration	

		manager reporting that the new process has allowed the service to have all the vital information it needs prior to admission. They reported that the process was an opportunity to show residents and their whānau that admission was not a 'business transaction' but a chance for staff to show that they genuinely care about residents and their wellbeing, so that on admission day, they felt like they were 'coming home'. The new process has been so successful that it is being rolled out to the whole of the HLL organisation in line with its values of 'people first' and 'working better together'.	
Criterion 3.2.2 Care or support plans shall be developed within service providers' model of care.	CI	The service identified that conversations about death and dying between the resident, whānau, and staff can be difficult. Residents often avoid the subject because they do not want to burden their whānau with any responsibility, or they are too afraid to ask about the process. Whānau are often not sure how to approach the subject. This often limited preparation and created uncertainty in how best to respect and honour personal, spiritual, and cultural values at the end of life. To address this, in April 2025 the service introduced a visible, respectful protocol to acknowledge residents and their whānau when residents come to end-of-life care. The approach used followed Te Whare Tapa Whā model of care, which values the strength of whānau support and meaningful connections. It supports wellbeing for the dying resident (tinana), cares for mental and emotional health for the resident and their whānau (hinengaro), and honours the spiritual aspect of the journey (wairua). Whānau were included every step of the way, recognising that healing and comfort come from being surrounded by love, understanding,	The care home has introduced an initiative to support end-of-life care in a way that upholds the wairua of the dying resident and supports whānau and others to manage this process respectfully. This is achieved through the use of visual cues that are understood by people within and outside the service, including staff, other residents, visitors, and contractors. Processes were in place to respectfully manage the palliative process and respect the tūpapāku as they make their final journey from the home. While care planning activities are required to be developed within the service provider's model of care, this initiative for the dying resident and their whānau goes beyond the required full attainment of the criteria, and a continuous improvement rating was given.

		and respect. The protocol introduced centred around the use of a 'rainbow blanket' and discrete signage (a discrete rainbow koru on the resident's door) to acknowledge the resident is in the end-of-life stage of their journey. Alongside this is a 'rainbow box' that consists of a range of items to encourage emotional and spiritual interaction between residents, whānau and staff (such as aromatherapy oils and vaporiser, music, a bible, tissues, hand cream, lip balm, and a book of poems). Staff, other residents, visitors, and regular contractors were educated in the meaning of the symbols and expected behaviours when these were in place (such as being respectful of noise). Residents and whānau were informed about the initiative to ensure it was understood as a gesture of aroha, respect, and cultural responsiveness. The initiative aligns with the facility's tikanga around death, dying, and the aftercare of tūpāpaku. Following death, a 'good image' photograph or a symbol chosen by the whānau to represent the deceased resident (at the choice of the whānau) is displayed in the entryway at Annie Brydon with a candle, so that other residents, whānau and staff can pay their respects to the deceased resident. Any resident who has been close to the deceased resident is informed prior. The photograph stays in place until after the funeral. In doing this, the home celebrates life and shares the grief felt with the passing of a resident. On the exit of the tūpapāku, residents and staff form a 'guard of honour' as the resident leaves the home for the last time. If whānau consent, karanga (a call representing and paying tribute to the deceased) is performed to open the grief and acknowledge the connection between the living and the dead and to send them on their way to their ancestors.	

		The outcome of this initiative is that: • Residents were not disturbed unnecessarily, and whānau were provided with the privacy and support they required. • The home takes on the wairua (spirit of the person) and respect deserving of the journey being undertaken by the resident. • The rainbow blanket starts at the feet of the resident and is pulled up gradually as the resident nears the end-of-life, visually symbolising the stage the resident is at in the journey. • Clinical and non-clinical staff are visually aware that the resident is on this journey. • Resident and staff gather around the photograph or symbol of the deceased resident, sharing stories and remembrances. A further initiative, which has not yet been completed, is a memory tree. This is currently in the development phase, and the design will be based on a pōhutukawa tree, symbolically connecting the traditions of the past to tūpuna (ancestors). The Pōhutukawa star in the Matariki cluster is recognised as the keeper of memories. Feedback from the initiative has been positive. Whānau, staff and visitor feedback (sighted) received by the CHVM confirms that the care home acknowledges and respects residents' end-of-life journeys, with each person's values, cultural practices, and beliefs being honoured.	

End of the report.