

Presbyterian Support Southland - Vickery Court

Introduction

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

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

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

You can view a full copy of the standard on the Manatū Hauora website by clicking [here](#).

The specifics of this audit included:

Legal entity: Presbyterian Support Southland

Premises audited: Vickery Court

Services audited: Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

Dates of audit: Start date: 3 February 2026 End date: 4 February 2026

Proposed changes to current services (if any): The service has also been verified as suitable to provide disability services for younger people with lifelong disabilities (physical).

Total beds occupied across all premises included in the audit on the first day of the audit: 83



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 haumarū | 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

PSS Vickery Court is part of the Presbyterian Support Southland (PSS) Enliven organisation. The service is one of four aged care facilities governed by the PSS Trust Board. The service is certified to provide rest home and hospital (medical and geriatric) levels of care for up to 88 residents. There were 83 residents on the days of the audit.

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

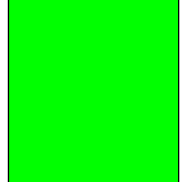
There has been changes in management since the last audit. The facility manager is a registered nurse and has been in the role for five months. They have previous experience in aged care clinical management and in education. The clinical manager has been in the role for 18 months and has previous experience as a registered nurse within Presbyterian Support Southland. They are supported by a quality manager and wider PSS management team. The healthcare assistants' workforce has remained stable within the facility.

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

The following three shortfalls from the previous audit have not yet been addressed: monitoring of care, evaluation of care plans within timeframes, and monitoring of medication room temperatures.

This audit identified further shortfalls related to assessments and care planning and management and administration of medication.

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. |
|---|---|--|

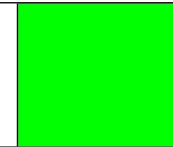
There is a Māori health plan in place for the organisation. Te Tiriti o Waitangi is embedded and enacted across policies, procedures, and delivery of care. The service recognises Māori mana motuhake and this is reflected in the Māori health plan and business plan. A Pacific health plan is in place which ensures cultural safety for Pacific peoples, embracing their worldviews, cultural, and spiritual beliefs.

Vickery Court 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 (the Code), and complainants are kept fully informed following any investigation.

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.

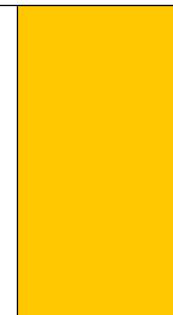
Vickery Court has a well-established and robust governance structure, including clinical governance that is appropriate to the size and complexity of the service provided. The strategic plan includes a mission statement and operational objectives which are regularly reviewed. Barriers to health equity are identified, addressed and services delivered that improve outcomes for Māori.

The service has effective quality and risk management systems in place that take a risk-based approach and progress is regularly evaluated against quality outcomes. There is a process for following the National Adverse Event Reporting policy and management have an understanding and comply with statutory and regulatory obligations in relation to essential notification reporting.

There is a staffing and rostering policy. An orientation programme and staff training plan are in place to support staff in delivering safe quality care.

Ngā huarahi ki te oranga | Pathways to wellbeing

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




Some subsections applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

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

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

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

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

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

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

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

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

Subsections applicable to this service fully attained.

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

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

Here taratahi | Restraint and seclusion

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

Subsections applicable to this service fully attained.

The restraint coordinator is the clinical manager. The facility has no residents using restraint. 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 | 0 | 2 | 0 | 0 |
| Criteria | 0 | 44 | 0 | 0 | 6 | 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 |
|---|-------------------|--|
| <p>Subsection 1.1: Pae ora healthy futures</p> <p>Te Tiriti: Māori flourish and thrive in an environment that enables good health and wellbeing.</p> <p>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.</p> | FA | <p>A Māori health plan is documented for the service, which Presbyterian Support Southland (PSS) Vickery Court 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.</p> |
| <p>Subsection 1.2: Ola manuia of Pacific peoples in Aotearoa</p> <p>The people: Pacific peoples in Aotearoa are entitled to live and enjoy good health and wellbeing.</p> <p>Te Tiriti: Pacific peoples acknowledge the mana whenua of Aotearoa as tuakana and commit to supporting them to achieve tino rangatiratanga.</p> <p>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.</p> | FA | <p>The Pacific Health and Wellbeing Plan 2020-2025 is the basis of the PSS cultural safety for Pasifika Peoples and their Fonua policy. The principles/objectives of the policy are acknowledging Pacific people by maintaining respectful relationships, creating equitable access to services, valuing families, and provide high quality health care. The policy recognises Pacific models of care and include Kakaha, Fonofale and Fonua model of care. At the time of the audit there were no residents who identified as Pasifika. There were Pacific staff who could confirm that cultural safety for Pacific peoples, their worldviews, cultural, and spiritual beliefs are embraced at PSS Vickery Court.</p> |

| | | |
|--|-----------|---|
| <p>Subsection 1.3: My rights during service delivery</p> <p>The People: My rights have meaningful effect through the actions and behaviours of others.</p> <p>Te Tiriti: Service providers recognise Māori mana motuhake (self-determination).</p> <p>As service providers: We provide services and support to people in a way that upholds their rights and complies with legal requirements.</p> | <p>FA</p> | <p>Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers Rights (the Code) is displayed in English and te reo Māori. The facility manager interviewed, demonstrated how it is also provided in welcome packs in the language most appropriate for the resident, to ensure they are fully informed of their rights. Interviews with three family/whānau (two hospital and one rest home) and six residents (four hospital level care and two rest home level care) confirmed they are informed of their rights and their choices are respected. Interviews with young people with disabilities stated that their rights related to choice and independence have been upheld.</p> |
| <p>Subsection 1.5: I am protected from abuse</p> <p>The People: I feel safe and protected from abuse.</p> <p>Te Tiriti: Service providers provide culturally and clinically safe services for Māori, so they feel safe and are protected from abuse.</p> <p>As service providers: We ensure the people using our services are safe and protected from abuse.</p> | <p>FA</p> | <p>The PSS organisational policies provide guidelines to prevent any form of institutional racism, discrimination, coercion, harassment, or any other exploitation. There are established policies, and protocols to respect resident's property, including an established process to manage and protect resident finances. All staff at PSS Vickery Court are trained in and aware of professional boundaries, as evidenced in orientation documents and ongoing education records. Staff interviewed (six healthcare assistants [HCAs], six registered nurses (RN), one cook, one domestic supervisor and one maintenance person) and management interviewed (facility manager, quality manager, clinical manager) evidenced an understanding of professional boundaries.</p> |
| <p>Subsection 1.7: I am informed and able to make choices</p> <p>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.</p> <p>Te Tiriti: High-quality services are provided that are easy to access and navigate. Providers give clear and relevant messages so that individuals and whānau can effectively manage their own health, keep well, and live well.</p> | <p>FA</p> | <p>Resident files reviewed included completed general consent forms and consents for influenza and Covid-19 vaccinations. Residents and family/whānau interviewed could describe what informed consent was and knew they had the right to choose. Consent forms were appropriately signed by the resident or activated enduring power of attorney (EPOA). All documentation regarding EPOA, and the appropriate activation is on file; this was evident in the resident files reviewed. All files reviewed included documentation relating to shared goals of care with evidence of input from family/whānau where appropriate.</p> |

| | | |
|---|-----------|--|
| <p>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.</p> | | |
| <p>Subsection 1.8: I have the right to complain</p> <p>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.</p> <p>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.</p> | <p>FA</p> | <p>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 20 complaints made since the previous audit (four in 2024, 15 in 2025 and one in 2026) which were resolved to the satisfaction of the complainants.</p> <p>One complaint was made through the Health and Disability Commissioner (HDC) on 20 August 2025. The service provided all required information and met with the complainant and extended family on the 25th of September 2025. The complaint was withdrawn in October 2025.</p> <p>Complaints documentation reviewed included follow up and outcome letters. Complaints documentation evidenced that complaints are being managed in accordance with guidelines set by HDC. The facility manager and quality manager are responsible for the management of complaints. Residents or family/whānau making a complaint can involve an independent support person in the process if they choose. The complaints process is linked to advocacy services. Discussions with residents and family/whānau confirmed that they were provided with information on the complaints process and remarked that any concerns or issues they had, were addressed promptly. Information about the support resources for Māori is available to staff to assist Māori in the complaints process. Interpreters contact details are available. The facility manager acknowledged their understanding that for Māori, there is a preference for face-to-face communication, and to include family/whānau participation.</p> |
| <p>Subsection 2.1: Governance</p> <p>The people: I trust the people governing the service to have</p> | <p>FA</p> | <p>PSS Vickery Court is part of the Presbyterian Support Southland (PSS) Enliven organisation. The service is one of four aged care facilities</p> |

| | |
|---|---|
| <p>the knowledge, integrity, and ability to empower the communities they serve.</p> <p>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.</p> <p>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.</p> | <p>governed by the PSS Trust Board. The service is certified to provide rest home and hospital (medical and geriatric) levels of care for up to 88 residents.</p> <p>On the days of audit there were 83 residents in total: 50 at hospital level care, including four residents on a younger person with a disability (YPD) contract and three residents funded under an Accident Compensation Contract (ACC); and 33 residents at rest home level of care, including one on a YPD contract. All other residents were funded under the Age-Related Residential Care Services Agreement (ARRC). This audit also verified that this service is suitable to provide services to younger people with lifelong disabilities (physical).</p> <p>There are 84 dual purpose beds, including four double rooms intended to be used for married couples. Three double rooms were occupied by married couples; one was vacant at the time of the audit.</p> <p>There is a PSS Charter and Strategic Plan 2021-2026 that documents the vision, values, and key service objectives. The chief executive and senior leadership team is responsible for delivery on the strategic plan objectives, and the documents evidence a commitment to regulatory and legislative obligations within the Enliven philosophy framework. Management reports on progress against the plan on a quarterly basis. The strategic plan reflects a leadership commitment to collaborate with Māori, aligns with the Ministry of Health strategies, and addresses barriers to equitable service delivery to improve positive outcomes for Māori.</p> <p>A clinical governance committee (created by the Trust Board) meets two-monthly, and reviews reports monthly. Its membership is from the Board, and externally with clinical expertise from two external nurse practitioners, who were added to the committee to extend clinical support. The quality improvement plan is reviewed three-yearly (with updates provided quarterly). The clinical governance committee reviews the risks for the PSS Enliven (aged care) service at their bi-monthly meetings, where this information is reported to the Board. Site specific goals relate to clinical effectiveness, effective cultural journey, and risk management is overseen and reported on by the quality manager.</p> <p>There have been changes in management since the last audit. The facility manager is a RN and maintains an annual practising certificate. They have been in the role since October 2025 and have previous experience as a</p> |
|---|---|

| | | |
|--|-----------|--|
| | | <p>clinical manager and in health management. They are supported by a clinical manager, quality manager, head housekeeper, and wider PSS management team. The healthcare assistants' workforce has remained stable within the facility. The facility manager and clinical manager have completed the required eight hours of professional development activities related to managing an aged care facility.</p> |
| <p>Subsection 2.2: Quality and risk</p> <p>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.</p> <p>Te Tiriti: Service providers allocate appropriate resources to specifically address continuous quality improvement with a focus on achieving Māori health equity.</p> <p>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.</p> | <p>FA</p> | <p>PSS Vickery Court is implementing a quality and risk management programme. The quality and risk management systems include performance monitoring through internal audits and through the collection of clinical indicator data. Quarterly quality and general staff meetings provide an avenue for discussions in relation to (but not limited to) quality data; health and safety; infection control/pandemic strategies; complaints; staffing; and education. Internal audits, meetings, and collation of data were documented as taking place as scheduled. Clinical related internal audits are completed by the quality manager and facility manager (RN) and reported in the monthly clinical quality report, and monthly PSS clinical managers' meetings.</p> <p>Corrective actions were documented where indicated to address service improvements with evidence of progress and sign off when achieved. Quality and health and safety goals and progress towards attainment are discussed at quality/risk and general staff meetings. Quality data and trends are added to meeting minutes. There was evidence of high staff attendance at meetings. Quality improvement projects included the use of pneumatic leg compression equipment to replace the use of compression stockings. All policies are reviewed three yearly. The medication management policy includes oxygen therapy management, and the fluid and nutrition management policies were reviewed and updated in October 2023 to reflect best practice.</p> <p>Monthly internal and quarterly external benchmarking of quality data, including ethnicity trends, provide a critical analysis to organisational practice and to improve health equity. The residents and family/whānau survey completed in July 2025 evidence overall satisfaction with service delivery.</p> <p>A health and safety system is in place. Hazard identification forms are</p> |

| | | |
|--|----|--|
| | | <p>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, and communication with family is clearly documented however follow-up action(s) are not always documented as required, evidenced in a sample of fifteen accident/incident records reviewed. Incident and accident data is collated monthly and analysed. Results are discussed in the quality/risk meeting, general staff meetings, and at handover. Each event involving a resident reflected a clinical assessment and a timely follow up by an RN. Risks and action plans to minimise future risks are not always identified (link 3.2.4)</p> <p>Young people with lifelong disabilities are encouraged to participate in feedback related to service delivery as evidenced in interviews with two younger people.</p> <p>Discussions with the facility manager and clinical manager evidenced awareness of their requirement to notify relevant authorities in relation to essential notifications. There have been events notified under Section 31 including change of facility and clinical management and the required Severity Assessment Code (SAC) reports to the Health Quality and Safety Commission. There have been three outbreak events reported appropriately.</p> |
| <p>Subsection 2.3: Service management</p> <p>The people: Skilled, caring health care and support workers listen to me, provide personalised care, and treat me as a whole person.</p> <p>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.</p> <p>As service providers: We ensure our day-to-day operation is managed to deliver effective person-centred and whānau-centred services.</p> | FA | <p>There is staffing requirements policy and procedure that describes rostering and staffing rations in an event of residents' acuity change and outbreak management. Presbyterian Support Southland policy includes the rationale for staff rostering and skill mix. Rosters reviewed evidenced that every effort is undertaken to ensure staff are replaced when sick.</p> <p>The facility manager works Monday to Friday and oversees the day-to-day operations of the dual-purpose area at PSS Vickery Court. The facility manager and clinical manager provide oversight on clinical and operational aspects of the service in the dual-purpose units and are rostered to ensure coverage over seven days. Both managers share the clinical after hours on-call roster. They are supported by a 24/7 RN availability in the dual-purpose unit. The HCAs reported they felt</p> |

| | | |
|---|----|---|
| | | <p>supported, and the workload is manageable. The roster takes into consideration the design of the building. There are three enrolled nurses (ENs) who support service delivery.</p> <p>The roster evidenced sufficient registered nurses and HCAs are allocated to the roster to ensure residents are well supported. The roster is overseen by the administrator and facility manager to ensure staffing is covered in each wing. There are separate staff dedicated to activities, kitchen, cleaning, and laundry.</p> <p>The facility manager and quality manager oversee the centralised education programme by ensuring staff attendance. There is an annual education and training schedule being implemented. The education and training schedule lists compulsory training, which includes (but not limited to) cultural awareness training; nutrition and hydration; oxygen management; compression stocking as part of cardiorespiratory condition management; privacy; and confidentiality. Staff receive training in the principles of Enabling Good Lives. All training has been completed as scheduled, and high attendance numbers are documented for each topic.</p> <p>Staff last attended cultural awareness training at their orientation in November 2025. Training statistics and staff education reports are completed monthly by PSS Enliven support office to ensure staff training is monitored effectively. Registered nurses are supported with opportunities through the online learning platform, and have completed critical thinking training, early sepsis management training, and end of life care training. Registered nurses and HCAs complete annual competencies (sighted) related to their roles. There are six of the twelve RNs that have interRAI competencies.</p> <p>The service supports and encourages HCAs to obtain a New Zealand Qualification Authority (NZQA) qualification. There are 49 HCAs employed. Eighty percent of HCAs have obtained a level 3 and above. There are online training and education and resources available on the intranet. An Enliven training policy is being implemented. All staff are required to complete competency assessments as part of their orientation.</p> |
| Subsection 2.4: Health care and support workers | FA | Eight staff files (three RNs [including clinical manager], one activities officer, one cook and three HCAs) reviewed included evidence of |

| | | |
|--|------------------------|---|
| <p>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.</p> <p>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.</p> | | <p>completed orientation, training and competencies and professional qualifications on file where required. There are job descriptions in place for all positions that includes outcomes, accountability, responsibilities, authority, and functions to be achieved in each position. A register of practising certificates is maintained for all health professionals.</p> <p>The service has a role-specific orientation programme in place that provides new staff with relevant information for safe work practice and includes buddying when first employed. Competencies are completed at orientation. The service demonstrates that the orientation programme supports RNs and HCAs to provide a culturally safe environment for Māori. All staff who have been employed for a year or more have a current performance appraisal on file.</p> |
| <p>Subsection 3.2: My pathway to wellbeing</p> <p>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.</p> <p>Te Tiriti: Service providers work in partnership with Māori and whānau, and support their aspirations, mana motuhake, and whānau rangatiratanga.</p> <p>As service providers: We work in partnership with people and whānau to support wellbeing.</p> | <p>PA Moderate</p> | <p>Six resident files three hospital (including one ACC and one YPD) and three rest home were reviewed for this audit. The registered nurses are responsible for completing an initial assessment and care plan, under the banner of getting to know me assessment tool. There is evidence of resident and family/whānau involvement in the interRAI assessments and long-term care plan reviews. Initial assessments, initial care plans, interRAI assessments and long-term care plans were not always completed within the stated timeframes of the contract.</p> <p>For the resident files reviewed, the outcomes from assessments and risk assessments are not always reflected into care plans. The care plans identify resident focussed goals however the care plans do not always identify key assessed risks, including medical risks and interventions reflective of interRAI assessments described in sufficient detail to address assessed needs. Other available information, such as discharge summaries, medical and allied health notes, and consultation with the resident, family/whānau or significant others are included in the resident electronic file. Three care plans required review however not all had been evaluated within the required six-month timeframe. Risk assessments are scheduled for completion six-monthly or earlier due to health changes however this is not always completed as scheduled. The previous partial attainment #3.2.5 related to timeliness of care plan evaluations has not yet been addressed. Care plans have not been consistently updated when</p> |

| | |
|--|---|
| | <p>there were changes in health condition and identified needs.</p> <p>A nurse led primary care practice (Nurse Practitioners [NP]) is contracted to provide medical service to residents eight hours a week. The NP visits twice weekly and is available as needed. The NP completes medical admissions, three-monthly reviews and sees all residents of concern. The NP interviewed stated that the nursing team demonstrates competence with their assessments and referrals. The NP added that the clinical expertise provided by management and registered nurses was excellent and they stated that requests for clinical visits was appropriate and timely. The NP commented positively on the care the residents received.</p> <p>Residents' electronic files identify the integration of NP and allied health professional input into care, and a multidisciplinary team approach is evident. A physiotherapist is contracted once a week and supported by an employed physiotherapy assistant who works five hours a day each weekday. PSS contracted dietitian is available by referral. A podiatrist visits six-weekly. Other allied health professionals involved in care include hospice, clinical nurse specialists, and medical specialists from Health New Zealand.</p> <p>Healthcare assistants interviewed could describe a verbal and written handover at the beginning of each duty that maintains a continuity of service delivery. Progress notes are written each shift by the HCAs. The registered nurses write weekly clinical summary notes and complete progress notes more frequently if needed to reflect an accurate presentation of the current health status of the residents.</p> <p>Residents interviewed reported their needs and expectations were being met. When a resident's condition alters, the clinical manager or registered nurse initiates a review with the NP. Family/whānau or EPOA were notified of all changes to health, including infections, accident/incidents, NP visits, medication changes, and any changes to health status.</p> <p>The wound register identified skin tears, skin lesions, chronic wounds and six facility-acquired pressure injuries (suspected deep tissue and stage 2). A sample of wounds were reviewed. The electronic wound care plan documents the wound management plans, assessments, and evaluations, with supporting photographs. Review of wounds and dressing changes occur as specified in the plans. Referrals are completed to the wound nurse specialist for additional input for complex wounds.</p> |
|--|---|

| | | |
|---|------------------------|--|
| | | <p>Healthcare assistants interviewed stated there are adequate clinical supplies and equipment provided, including continence, wound care supplies, and pressure injury prevention resources. There is also access to a continence specialist as required. Monitoring includes repositioning; intentional grounding; food and fluid; bowel chart; blood pressure; weight; pain; behaviour; neurological observations; and blood sugar levels. Care plans do not always reflect the required health monitoring interventions for individual residents, and monitoring charts reviewed were not always completed as scheduled. Short term acute issues are addressed in care plans and progress notes where appropriate.</p> <p>A sample of fifteen incidents were reviewed including ten where neurological observations were implemented. Neurological observations reviewed did not consistently follow policy timeframes. The previous partial attainment #3.2.4 related to monitoring of neurological observations and has not yet been addressed.</p> |
| <p>Subsection 3.4: My medication</p> <p>The people: I receive my medication and blood products in a safe and timely manner.</p> <p>Te Tiriti: Service providers shall support and advocate for Māori to access appropriate medication and blood products.</p> <p>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.</p> | <p>PA Moderate</p> | <p>Medication management policies are available for safe medicine management. All staff (registered nurses, enrolled nurses, and medication competent HCAs) who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided. Staff were observed to be safely administering medications. Healthcare assistants could describe their role regarding medication administration. All medications are checked on delivery against the medication chart, and any discrepancies are fed back to the supplying pharmacy. Regular physical checks and reconciliation of medication occurs.</p> <p>Medications were appropriately stored across three treatment rooms. The temperature monitoring of all treatment rooms and medication fridges was completed however this was not always completed as scheduled. The previous partial attainment # 3.4.1 has not yet been addressed. Temperature readings were within acceptable ranges. All medications, including the bulk supply order, are checked weekly. All eyedrops have been dated on opening.</p> <p>Twelve medication charts were reviewed. The medication charts reviewed identified that the NP reviewed all resident medication charts three-</p> |

| | | |
|--|----|---|
| | | <p>monthly, and each chart has photo identification and allergy status identified. One resident self-administers their own medications however the resident's competency to do so has not been reviewed three monthly as per policy. The residents' medications were safely stored in the resident's room.</p> <p>No standing orders are in use. Pro re nata (PRN) medications are charted and administered when required; however, not all administered PRN medications were monitored for effectiveness or outcome.</p> <p>Residents and family/whānau are updated around medication changes, including the reason for changing medications and side effects. This is documented in the progress notes.</p> |
| <p>Subsection 3.5: Nutrition to support wellbeing</p> <p>The people: Service providers meet my nutritional needs and consider my food preferences.</p> <p>Te Tiriti: Menu development respects and supports cultural beliefs, values, and protocols around food and access to traditional foods.</p> <p>As service providers: We ensure people's nutrition and hydration needs are met to promote and maintain their health and wellbeing.</p> | FA | <p>The meals at PSS Vickery Court are all prepared and cooked on site. The kitchen was observed to be clean, well-organised, well equipped, and a current approved food control plan expires on 11 June 2026.</p> <p>The cook receives resident dietary information (including food allergies) from the RNs on admission and is notified of any changes to dietary requirements. Dislikes and special dietary requirements (vegetarian, dairy free, pureed foods) are accommodated. The cook reports they accommodate residents' requests.</p> |
| <p>Subsection 3.6: Transition, transfer, and discharge</p> <p>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.</p> <p>Te Tiriti: Service providers advocate for Māori to ensure they and whānau receive the necessary support during their transition, transfer, and discharge.</p> <p>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</p> | FA | <p>Planned discharges or transfers were coordinated in collaboration with residents and family/whānau to ensure continuity of care and to manage associated risks. Resident change, transfer, or termination policy and procedures are documented to ensure discharge, or transfer of residents is undertaken in a timely and safe manner.</p> <p>The registered nurses explained the transfer between services includes a comprehensive verbal handover and the completion of specific transfer documentation.</p> |

| | | |
|--|----|--|
| support. | | |
| <p>Subsection 4.1: The facility</p> <p>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.</p> <p>Te Tiriti: The environment and setting are designed to be Māori-centred and culturally safe for Māori and whānau.</p> <p>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.</p> | FA | <p>There is a current building warrant of fitness. The environment is inclusive of peoples' cultures and supports cultural practices. Furthermore, the environment is suitable for younger people with lifelong disabilities and their motorised mobility equipment. A recently appointed full-time maintenance and projects team leader oversees maintenance of the site, a team of five maintenance workers, and contractor management. Essential contractors, such as plumbers and electricians, are available 24 hours a day, every day as required.</p> <p>There is an annual maintenance plan that includes electrical testing and tagging, resident's equipment checks, call bell checks, calibration of medical equipment, and monthly testing of hot water temperatures. Visual checks of all electrical appliances belonging to residents are checked when they are admitted. Testing and tagging of resident's electrical equipment is completed annually. Checking and calibration of medical equipment, hoists and scales is completed annually.</p> |
| <p>Subsection 5.2: The infection prevention programme and implementation</p> <p>The people: I trust my provider is committed to implementing policies, systems, and processes to manage my risk of infection.</p> <p>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.</p> <p>As service providers: We develop and implement an infection prevention programme that is appropriate to the needs, size, and scope of our services.</p> | FA | <p>There is a defined and documented infection control (IC) programme implemented that was developed with input from external IC services and reviewed annually. The IC programme was approved by the clinical governance committee and is linked to the organisation wide risk programme. The infection control manual outlines a comprehensive range of policies, standards, and guidelines, and includes defining roles, responsibilities and oversight, the infection control team, and training and education of staff. The clinical manager(RN) is the infection prevention and control coordinator and has completed infection control training related to their role.</p> <p>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.</p> |

| | | |
|--|-----------|---|
| <p>Subsection 5.4: Surveillance of health care-associated infection (HAI)</p> <p>The people: My health and progress are monitored as part of the surveillance programme.</p> <p>Te Tiriti: Surveillance is culturally safe and monitored by ethnicity.</p> <p>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.</p> | <p>FA</p> | <p>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 database and surveillance of all infections (including organisms) is collated onto a monthly infection summary. This data is monitored and analysed for trends, monthly and annually. Benchmarking occurs. The service incorporates ethnicity data into surveillance methods and data captured around infections. Infection control surveillance is discussed at quality/risk and staff meetings. Meeting minutes and graphs are displayed for staff. Action plans are required for any infection rates of concern. Internal infection control audits are completed with corrective actions for areas of improvement. The service receives regular notifications and alerts from Health New Zealand.</p> <p>Infections, including outbreaks, are reported, and reviewed, so improvements can be made to reduce healthcare acquired infections (HAI). Education includes monitoring of antimicrobial medication, infection control, aseptic technique, and transmission-based precautions. Three outbreaks were documented since the last audit and records evidence these were well documented and managed.</p> |
| <p>Subsection 6.1: A process of restraint</p> <p>The people: I trust the service provider is committed to improving policies, systems, and processes to ensure I am free from restrictions.</p> <p>Te Tiriti: Service providers work in partnership with Māori to ensure services are mana enhancing and use least restrictive practices.</p> <p>As service providers: We demonstrate the rationale for the use of restraint in the context of aiming for elimination.</p> | <p>FA</p> | <p>The governance body demonstrate a commitment to eliminating restraint and remains restraint free. The facility maintains a focus on ensuring care is provided in the least restrictive way possible. There were no residents using restraint. A registered nurse undertakes the restraint portfolio and drives the ongoing philosophy of eliminating restraint. The restraint policy confirms that restraint consideration and application must be made in partnership with family/whānau, and the choice of the device must be the least restrictive possible. When restraint is considered, the facility works in partnership with the resident and family/whānau to ensure services are mana-enhancing.</p> <p>Training for all staff occurs at orientation and annually, as sighted in the training records. Staff have been trained in the least restrictive practice, safe restraint practice, alternative cultural-specific interventions, and de-</p> |

| | | |
|--|--|--|
| | | escalation techniques. Restraint competencies are completed on orientation and annually. |
|--|--|--|

Specific results for criterion where corrective actions are required

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

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

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

| Criterion with desired outcome | Attainment Rating | Audit Evidence | Audit Finding | Corrective action required and timeframe for completion (days) |
|--|------------------------|---|---|--|
| <p>Criterion 3.2.1</p> <p>Service providers shall engage with people receiving services to assess and develop their individual care or support plan in a timely manner. Whānau shall be involved when the person receiving services requests this.</p> | <p>PA Moderate</p> | <p>All initial assessments and care plans are completed by a registered nurse. The policy provides guidance to ensure that an initial care plan is developed within 24 hours of admission with detailed information to guide caregivers on care delivery for the residents however not all files reviewed had initial assessments and care plans completed within the required time frame. InterRAI assessments and long-term care plans are scheduled six monthly however this has not always occurred as scheduled.</p> | <p>Initial assessments, and initial care plans were not completed within 48 hrs for one hospital (ACC) and one rest home resident; and two initial interRAI assessments (one hospital and one rest home) were not completed within 21 days.</p> <p>Initial long term care plans were not completed within 21 days for one hospital and two rest home residents.</p> <p>Follow up interRAI assessments were not completed within six months for two rest home residents.</p> | <p>i)- ii) Ensure all initial assessments and care plans are completed within required timeframes.</p> <p>iii) Ensure six monthly interRAI assessments are completed within scheduled timeframes.</p> <p>60 days</p> |

| | | | | |
|---|------------------------|--|---|---|
| <p>Criterion 3.2.3</p> <p>Fundamental to the development of a care or support plan shall be that:</p> <p>(a) Informed choice is an underpinning principle;</p> <p>(b) A suitably qualified, skilled, and experienced health care or support worker undertakes the development of the care or support plan;</p> <p>(c) Comprehensive assessment includes consideration of people's lived experience;</p> <p>(d) Cultural needs, values, and beliefs are considered;</p> <p>(e) Cultural assessments are completed by culturally competent workers and are accessible in all settings and circumstances. This includes traditional healing practitioners as well as rākau rongoā, mirimiri, and karakia;</p> <p>(f) Strengths, goals, and aspirations are described and align with people's values and beliefs. The support required to achieve these is clearly documented and communicated;</p> <p>(g) Early warning signs and risks that may adversely affect a person's wellbeing are recorded, with a focus on prevention or escalation for appropriate intervention;</p> <p>(h) People's care or support plan identifies wider service integration as required.</p> | <p>PA Moderate</p> | <p>The registered nurses are responsible for the development of the care plan. Assessment tools, including cultural assessments, were completed to identify key risk areas. Alerts are indicated on the resident care plan and include (but not limited to) high falls risk, weight loss, wandering, and pressure injury risks. The registered nurses interviewed understand their responsibility in relation to assessment and care planning. There are comprehensive policies in place related to assessment and care planning; however, care plan interventions did not always reflect the current needs of the resident.</p> <p>Caregivers are knowledgeable about the care needs of the residents and the family/whānau interviewed were complimentary of the care provided. Progress notes and monitoring records evidence care delivery to the residents, reflective of their needs, as described by staff during interviews and confirmed by family/whānau interviewed. The findings related to care planning relates to documentation only.</p> | <p>Initial care plan for a recent ACC hospital admission did not provide detailed interventions to guide staff in the delivery of care in relation to equipment requirements (bariatric bed and electric chair), care of a plaster cast, circulation checks, and physio instructions.</p> <p>One hospital resident on a YPD contract did not have detailed interventions documented to guide staff in the delivery of care in relation to a choking risk and dietary requirements. The care plan for the same resident who was assessed as a moderate falls risk did not include falls prevention strategies.</p> <p>One rest home resident with fluid retention, dyspnoea and pneumatic compression treatments do not have related interventions documented.</p> <p>One rest home resident with recent deterioration, frequent falls and pain did not have related interventions documented.</p> | <p>(i)-(iv).Ensure that care plans reflects the residents' current needs with interventions documented that provide detailed information to guide staff in the delivery of care for the residents.</p> <p>60 days</p> |
|---|------------------------|--|---|---|

| | | | | |
|--|------------------------|--|--|--|
| <p>Criterion 3.2.4</p> <p>In implementing care or support plans, service providers shall demonstrate:</p> <p>(a) Active involvement with the person receiving services and whānau;</p> <p>(b) That the provision of service is consistent with, and contributes to, meeting the person's assessed needs, goals, and aspirations. Whānau require assessment for support needs as well. This supports whānau ora and pae ora, and builds resilience, self-management, and self-advocacy among the collective;</p> <p>(c) That the person receives services that remove stigma and promote acceptance and inclusion;</p> <p>(d) That needs and risk assessments are an ongoing process and that any changes are documented.</p> | <p>PA Moderate</p> | <p>There are comprehensive policies around all aspects of post fall management policies include monitoring of neurological observations. Monitoring is scheduled on paper documentation for repositioning, restraint monitoring, food and fluid intake, neurological observations, and intentional rounding however, not all monitoring has been completed as directed. The shortfall identified at the last audit to monitoring of care remains. The rating has increased from low risk to moderate and the time to address the shortfall has decreased from 90 to 60 days.</p> | <p>Inconsistent monitoring of neurological observations was identified in five of ten files reviewed following unwitnessed falls.</p> <p>Intentional rounding charts were not completed as scheduled for one hospital resident.</p> <p>Food and fluid intake was not fully documented for a rest home resident.</p> <p>Incident forms did not identify possible causes or follow up action plans to minimise future risks in ten of 15 incidents forms reviewed.</p> | <p>i-iii). Ensure monitoring occurs as scheduled.</p> <p>iv). Ensure incident forms identify risks and action plans to minimise future risks.</p> <p>60 days</p> |
| <p>Criterion 3.2.5</p> <p>Planned review of a person's care or support plan shall:</p> <p>(a) Be undertaken at defined intervals in collaboration with the person and whānau, together with wider service providers;</p> <p>(b) Include the use of a range of outcome measurements;</p> | <p>PA Moderate</p> | <p>Long-term care plans are formally evaluated by a registered nurse every six months, however, did not include the degree of achievement towards meeting desired goals and outcomes. The multi-disciplinary team review meetings provide evidence of collaboration with family/whanau. At the time of the audit, only one of three</p> | <p>Care plans evaluations did not reflect progress towards goals for the two files reviewed where evaluations had been completed.</p> <p>There was no evidence of updates to the care plan when progress was different from the expected goals as documented in the care plan evaluation e.g.</p> | <p>Ensure that evaluations of care plans reflect progress against the goals.</p> <p>Ensure that the care plan is updated when progress is different from the expected outcome.</p> |

| | | | | |
|---|-------------------------|---|--|---|
| <p>(c) Record the degree of achievement against the person's agreed goals and aspiration as well as whānau goals and aspirations; (d) Identify changes to the person's care or support plan, which are agreed collaboratively through the ongoing re-assessment and review process, and ensure changes are implemented; (e) Ensure that, where progress is different from expected, the service provider in collaboration with the person receiving services and whānau responds by initiating changes to the care or support plan.</p> | | <p>care plan for a resident who had been in the facility for more than six months had been evaluated within required timeframes. There was no evidence of updates to the care plan when the progress documented in the care plan evaluation was different from the expected outcome. The shortfall identified at the last audit to evaluation of care remains. The rating has increased from low risk to moderate and the time to address the shortfall has decreased from 90 to 60 days.</p> | <p>increased falls risk. Care plan evaluations were not completed within six months for two (rest home) of three residents where this was required.</p> | <p>Ensure care plan evaluations are completed as per policy. 90 days</p> |
| <p>Criterion 3.4.1 A medication management system shall be implemented appropriate to the scope of the service.</p> | <p>PA Moderate</p> | <p>PSS Vickery Court has medication policies and procedures documented that align with current legislation and best practice. A medications system is utilised. All medication charts are documented appropriately and include photographic identification. Allergies and sensitivities are all documented clearly. Medications are checked on delivery, and any errors are reported to the pharmacy. There are no expired medications on site. All medications are stored appropriately in three treatment rooms and three locked medication trolleys stored in the treatment rooms. Files sampled evidence PRN administration; however, review of administered PRN medications for</p> | <p>Medication room temperatures – Over the previous month, there were days where temperatures were not recorded for all three wings. Three out of 12 medication charts reviewed indicated administration of PRN medications; however, effectiveness was not consistently documented in the medication system or in the resident progress notes.</p> | <p>Ensure medication room temperatures are monitored daily as per policy. Ensure that effectiveness /outcomes of administered prn medications are documented. 30 days</p> |

| | | | | |
|--|---------------------------|--|--|--|
| | | <p>effectiveness were not consistently evaluated.</p> <p>Room and fridge temperatures have been monitored however room temperatures have not been consistently monitored as scheduled. The shortfall identified at the last audit to monitoring of room temperatures where medication is stored remains. The rating has remained as moderate however the time to address the shortfall has decreased from 60 to 30 days.</p> | | |
| <p>Criterion 3.4.6</p> <p>Service providers shall facilitate safe self-administration of medication where appropriate.</p> | <p>PA</p> <p>Moderate</p> | <p>The service has comprehensive policies in place for residents who wish to self-administer their own medications including a competency assessment, safe and secure storage, and three-monthly reviews. On the days of audit there was one resident self-administering medication, however a three-monthly review of competency had not been completed as per policy.</p> | <p>A self-medication competency review for a rest home resident has not been completed since April 2025.</p> | <p>Ensure self-administration of medication competencies are completed three monthly as per policy.</p> <p>60 days</p> |

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, there 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.