Presbyterian Support Central - Woburn Home

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 Central
Premises audited:	Woburn Home
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 31 March 2026 End date: 1 April 2026

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: 98

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

Presbyterian Support Central Woburn Home provides rest home, hospital (geriatric and medical), and dementia level of care for up to 100 residents. On the day of audit there were 98 residents

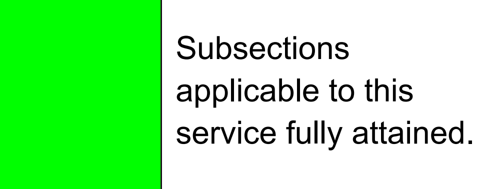
This surveillance audit was conducted against a subset of the Ngā Paerewa Health and Disability Services Standard 2021 and the contracts with Health New Zealand. The audit process included the review of policies and procedures, the review of resident and staff records, observations, and interviews with residents, family/whānau, management, staff, and a general practitioner.

There has been changes in management since the previous audit. The manager was appropriately qualified and supported by a clinical nurse manager, registered nurses and a team of experienced care and support staff. There are quality systems and processes documented. Feedback from residents and family/whānau was positive about the care and the services provided. An induction and in-service training programmes are in place to provide staff with appropriate knowledge and skills to deliver care.

One of three shortfalls identified at the previous audit relating to the collection and analysis of ethnicity has been addressed. Improvements continue to be required around implementation of aspects of the quality programme and building/ plant.

The shortfalls identified at this audit relate to staff training and performance appraisals.

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. The service recognises Māori mana Motuhake, and this is reflected in the Māori health plan. A Pacific health plan is in place which ensures cultural safety for Pacific peoples embracing their worldviews, cultural, and spiritual beliefs. Staff demonstrated an understanding of resident's rights and obligations and ensures residents are well informed in respect of these. There was no evidence of abuse, neglect, or discrimination. 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. Complaints are 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.

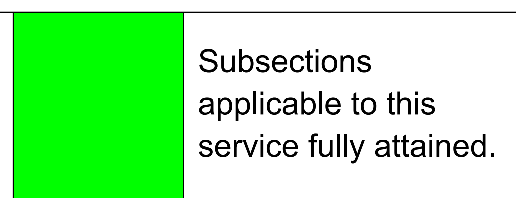
Hunga mahi me te hanganga | Workforce and structure

Includes five subsections that support an outcome where people receive quality services through effective governance and a supported workforce.		Some subsections applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

The Woburn Home business plan includes mission and values statements and operational objectives that are regularly reviewed. Barriers to health equity are identified, addressed, and services delivered that improve outcomes for Māori. The service has a documented quality and risk management systems that take a risk-based approach, to meet the needs of residents and their staff. There is 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. Quality improvement projects are implemented. Internal audits are documented as taking place as scheduled, with corrective actions as indicated.

There is a staffing and rostering policy. Human resources are managed in accordance with good employment practice. A role specific orientation programme and regular staff education and training are in place.

Ngā huarahi ki te oranga | Pathways to wellbeing

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

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

Medication policies reflect legislative requirements and guidelines. All staff responsible for administration of medication complete education and medication competencies. The medicine charts reviewed met prescribing requirements.

The kitchen staff cater to individual cultural and dietary requirements. The service has a current food control plan. Nutritious snacks were available 24/7.

All resident's transfers and referrals are coordinated with residents and family/whānau.

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

Includes two subsections that support an outcome where Health and disability services are provided in a safe environment appropriate to the age and needs of the people receiving services that facilitates independence and meets the needs of people with disabilities.		Some subsections applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

A maintenance plan is in place. All equipment has been tested, tagged, and calibrated as scheduled. The facility provides a homelike atmosphere.

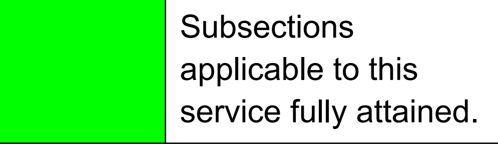
Te kaupare pokenga me te kaitiakitanga patu huakita | Infection prevention and antimicrobial stewardship

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.

Infection prevention management systems are in place to minimise the risk of infection to residents and visitors. The infection prevention programme is implemented and meets the needs of the organisation and provides information and resources for staff. Documentation evidenced that relevant infection prevention education is provided to staff as part of their orientation and as part of ongoing in-service education programme.

Surveillance data is undertaken, including the use of standardised surveillance definitions. Results of surveillance are acted upon, evaluated, and reported to relevant personnel in a timely manner. Surveillance information is used to identify opportunities for improvements. There has been one outbreak (Covid-19) since the previous 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 service aims for a restraint free service, and this is supported by the governing body and demonstrated within policies and procedures. There were no residents using any form of restraint at time of audit. The designated restraint coordinator is a clinical coordinator. Elimination of restraint use is included as part of the education and training plan.

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	15	0	2	2	0	0
Criteria	0	46	0	2	2	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Subsection	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Ngā paerewa Health and disability services standard

The following table contains the results of all the subsections assessed by the auditors at this audit. Depending on the services they provide, not all subsections are relevant to all providers and not all subsections are assessed at every audit.

For more information on the standard, please click here.

For more information on the different types of audits and what they cover please click here.

Subsection with desired outcome	Attainment Rating	Audit Evidence
Subsection 1.1: Pae ora healthy futures Te Tiriti: Māori flourish and thrive in an environment that enables good health and wellbeing. As service providers: We work collaboratively to embrace, support, and encourage a Māori worldview of health and provide high-quality, equitable, and effective services for Māori framed by Te Tiriti o Waitangi.	FA	A Māori health plan is documented for the organisation, which Woburn Home utilise as part of their strategy to embed and enact Te Tiriti o Waitangi in all aspects of service delivery. At time of audit there were residents and staff who identified as Māori. A review of the cultural aspect of the care plan provided evidence of how mana Motuhake is recognised and care provided is based upon the principles of Te Tiriti o Waitangi. The manager, clinical nurse manager and fifteen staff including six healthcare assistants (HCA), four registered nurses (RN), three clinical coordinator, one food services team leader and senior human resources (HR) advisor interviewed confirmed that services were delivered in a culturally supportive manner and outlined how Māori residents were supported to flourish within the environment.
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	FA	Woburn Home uses a model of care that reflects the values and beliefs which underpin the health service provision to Pacific people. At time of audit there were residents and staff who identified as Pasifika. Staff confirmed an awareness of and understanding of Pacific culture, values, beliefs and were knowledgeable about how to access community

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.		support for Pacific individuals.
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	A welcome package is provided that contains details about the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). The Code is displayed in English and te reo Māori within posters and brochures available throughout the facility. Five residents (four rest home and one hospital) and five family/whānau (two rest home, two dementia care and one hospital) were interviewed and reported the service is upholding the residents’ rights.
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	Policies guide staff to prevent any form of discrimination, harassment, or any other exploitation. There are established policies, and protocols to respect resident’s property, and an established process to manage and protect resident finances and property. All staff at are trained in and are aware of professional boundaries as evidenced in orientation documents, and ongoing education records. Staff demonstrated an understanding of professional boundaries when interviewed.
Subsection 1.7: I am informed and able to make choices The people: I know I will be asked for my views. My choices will be respected when making decisions about my wellbeing. If my choices cannot be upheld, I will be provided with information that supports me to understand why. Te Tiriti: High-quality services are provided that are easy to access and navigate. Providers give clear and relevant messages so that individuals and whānau can effectively manage their own health,	FA	There are policies around informed choice and consent. Staff and management confirmed their understanding of the organisational process to ensure informed consent for all residents (including Māori, who may wish to involve family/whānau for collective decision making). Resident files reviewed included general consent forms and consents for influenza and COVID-19 vaccinations. Consent forms were appropriately signed by the activated enduring power of attorney (EPOA) where this has been activated. All documentation regarding EPOA and activation is on file.

keep well, and live well. As service providers: We provide people using our services or their legal representatives with the information necessary to make informed decisions in accordance with their rights and their ability to exercise independence, choice, and control.		
Subsection 1.8: I have the right to complain The people: I feel it is easy to make a complaint. When I complain I am taken seriously and receive a timely response. Te Tiriti: Māori and whānau are at the centre of the health and disability system, as active partners in improving the system and their care and support. As service providers: We have a fair, transparent, and equitable system in place to easily receive and resolve or escalate complaints in a manner that leads to quality improvement.	FA	The service had a complaints policy/procedure in place that is provided to staff, residents, family/whānau and visitors. The complaints policy provided information related to complaints information, processes and timeframes required to identify, manage, and respectfully respond to complaints in keeping with right 10 of the Code. There have been six internal complaints received since the previous audit, six in 2025 and none in 2026 year to date. The complaints reviewed included an investigation, follow up and outcome replies to the complainant. The complaints process links to the advocacy service. Complaint forms are located at the entrance and in visible places throughout the facility or on request from staff. Residents or family/whānau making a complaint can involve an independent support person in the process if they choose. The Code and complaints process is visible, and available in te reo Māori, and English. Information about the support resources for Māori is available to staff to assist Māori in the complaints process. Interpreters contact details are available. The manager acknowledged their understanding that for Māori, there is preference for face-to-face communication and to include whānau. Residents' family/whānau interviewed confirmed they had been given information regarding how to make a complaint. They also reported if they have had any concerns that management were approachable, proactive and the issues had been quickly addressed.
Subsection 2.1: Governance The people: I trust the people governing the service to have the knowledge, integrity, and ability to empower the communities they serve. Te Tiriti: Honouring Te Tiriti, Māori participate in governance in	FA	Woburn Home is part of Presbyterian Support Central – Enliven and is located in Lower Hutt. Presbyterian Support Central Woburn Home provides hospital (medical and geriatric), rest home, and dementia levels of care for up to 100 residents. There are 29 rest home beds, 10 dual purpose beds, 35 hospital level beds and 26 dementia beds. At the time of the audit there were 98 residents: 33 rest home residents; 41 hospital

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.		residents, including one resident on a younger person with disability (YPD) contract and four residents on an Accident Compensation Corporation (ACC) agreement; and 24 dementia level residents including one resident on respite care. All other residents were on the age-related residential care (ARRC) agreement. The service is governed by a board of directors and a senior leadership team including a chief executive (CEO) who come from a wide variety of backgrounds cultures and experiences. To uphold the standards of governance the board prepares an Annual Legislative Compliance Statement that confirms adherence to all relevant laws and regulations. There is a current Enliven Central strategic plan in place with clear business goals to support their Enliven philosophy. The Eden principles of care is based on the Eden alternative that aims to promote positive ageing. The vision and values are posted in visible locations throughout the facility and are reviewed annually as well as the Eden principles. The senior leadership team receive progress updates on various topics, including staff and resident incidents, human resource matters, and escalated complaints. The business plan reflects links with Māori, aligns with the Ministry of Health strategies and addresses barriers to equitable service delivery. The service has identified external and internal risks and opportunities that include addressing possible inequities, and how these inequities plan to be addressed. Goals are regularly reviewed with evidence of sign off when met. Clinical governance is provided by the audit and risk committee. The clinical director is responsible to provide clinical oversight with support from four senior clinical advisors and the audit and risk committee. Clinical governance is overseen by the clinical nurse manager at Woburn Home. There are weekly updates given at handover and these talks focus on current clinical focus areas and the implementation of core values within the service. Monthly reports to senior leadership team reflect evidence of communicating quality and risk activities. There have been changes in management since the previous audit. In July 2. The manager and clinical nurse manager were appointed. Both the manager and the clinical nurse manager have held senior clinical roles within the facility prior to being appointed to these roles. They are supported by two clinical coordinators and a team of experienced care

		and support staff.
Subsection 2.2: Quality and risk The people: I trust there are systems in place that keep me safe, are responsive, and are focused on improving my experience and outcomes of care. Te Tiriti: Service providers allocate appropriate resources to specifically address continuous quality improvement with a focus on achieving Māori health equity. As service providers: We have effective and organisation-wide governance systems in place relating to continuous quality improvement that take a risk-based approach, and these systems meet the needs of people using the services and our health care and support workers.	PA Moderate	Woburn Home is implementing the organisational quality and risk management programme. The quality and risk management systems include performance monitoring through internal audits and through collection of clinical indicator data. The manager and clinical nurse manager lead the implementation of the quality programme. The programme involves all staff with every staff member expected to be active in implementing a quality approach when at work and participating in the quality programme. The service is implementing the organisations internal audit programme that includes all aspects of clinical care. Relevant corrective actions are developed and implemented to address any short falls. Progress against quality outcomes is evaluated. Reports are completed for each incident or accident with immediate action noted and any follow up action(s) required. Opportunities to minimise future risks are identified by the RNs. Relatives are informed following any incidents as confirmed in the eleven incident forms reviewed. The clinical nurse manager collates all the data and completes a monthly and annual analysis of results which is provided to staff and is accessible for the clinical governance team. Quality initiatives are documented, monitored, and reported related to improved clinical oversight and the reduction in skin tears. Monthly staff, quality, RN/clinical meetings are scheduled to provide an avenue for discussions in relation to quality data; health and safety; infection prevention; benchmarking (with other PSC facilities) complaints received; staff; and education. However, staff, quality, RN/clinical and resident meetings have not always been completed as per the required schedule. Not all agenda items, discussion points and corrective actions have been documented, followed up, and signed off when completed. The resident and family/whānau satisfaction surveys were completed in September 2025. There were no documented corrective actions implemented around keys areas for improvement from the surveys. The previous finding related to criterion # 2.2.2 remains. A health and safety system is in place. Hazard identification forms are completed, and up-to-date register was reviewed. Health and safety is discussed at staff meetings. Staff have completed training related to health and safety.

		Staff are kept informed on health and safety issues through the handover process and staff meetings. Discussions with the manager and clinical nurse manager evidenced their awareness of their requirement to notify relevant authorities in relation to essential notifications. A Section 31 notification was completed for the appointment of the manager in 2025. Four section 31 notifications and two severity assessment code (SAC) reports to Health Quality and Safety Commission (HQSC) have been completed since the previous audit. One COVID-19 outbreak was reported appropriately since the last audit.
Subsection 2.3: Service management The people: Skilled, caring health care and support workers listen to me, provide personalised care, and treat me as a whole person. Te Tiriti: The delivery of high-quality health care that is culturally responsive to the needs and aspirations of Māori is achieved through the use of health equity and quality improvement tools. As service providers: We ensure our day-to-day operation is managed to deliver effective person-centred and whānau-centred services.	PA Low	A policy is in place for determining staffing levels and skills mix for safe service delivery and defines staffing ratios to residents. Rosters implement the staffing rationale. The manager and clinical nurse manager both work full time from Monday to Friday. They are supported by the clinical coordinators, RNs, and a team of experienced care staff. The clinical coordinators are spread across seven days of the week. The manager is on call 24/7 for any operational related matters. The clinical nurse manager, with support from the clinical coordinators, provide clinical oversight at Woburn Home. The additional time allocated for clinical coordinators allows for completion of care plans, general practitioner clinics follow up, liaising with family/whānau and contribution to quality initiatives. There is a first aid trained staff member on duty 24/7. Separate cleaning and laundry staff are rostered. Staff on duty on the days of the audit were visible and were attending to call bells in a timely manner, as confirmed by all residents and family/whānau interviewed. Staff interviewed stated that the staffing levels are adequate for the resident needs and that the management team provide good support. There is an annual education and training schedule being implemented for 2026. The education and training schedule lists compulsory training required to be completed. Staff completion percentage rates for the mandatory and scheduled training topics including the aging process, code of rights, privacy/dignity, cultural safety, abuse/neglect, communication, pain management, restraint, and complaints

		management were low. There is an attendance register for each training session and an individual staff member record of training maintained electronically. Educational courses offered include in-services, online, and competency questionnaires. All RNs, a selection of HCAs and activities staff have completed first aid training. All RNs, enrolled nurses (EN) and HCAs who administer medications have current medication competencies. The service supports and encourages HCAs to obtain a New Zealand Qualification Authority (NZQA) qualification. There are 59 HCAs employed in total, with 45 HCAs having achieved a level three or four NZQA qualification. There are 19 HCAs allocated to work in the dementia unit, 17 have attained the relevant dementia unit standards and two were in progress of completing (both were within the 18-month timeframe limit). The RNs are supported to maintain their professional competency. There are implemented competencies for RNs related to specialised procedures and treatments medication, controlled drugs, restraint, and emergencies. There are ten RNs (including the clinical nurse manager and the three clinical coordinators and one EN, seven of the RNs have completed interRAI training.
Subsection 2.4: Health care and support workers The people: People providing my support have knowledge, skills, values, and attitudes that align with my needs. A diverse mix of people in adequate numbers meet my needs. Te Tiriti: Service providers actively recruit and retain a Māori health workforce and invest in building and maintaining their capacity and capability to deliver health care that meets the needs of Māori. As service providers: We have sufficient health care and support workers who are skilled and qualified to provide clinically and culturally safe, respectful, quality care and services.	PA Low	Eight staff files reviewed including one clinical nurse manager, two clinical coordinators, one RN and five HCAs evidenced implementation of the recruitment process, employment contracts, police checking and completed orientation. Policy and procedure are followed that ensures all prospective staff There are job descriptions in place for all positions that include outcomes, accountability, responsibilities, authority, and functions to be achieved in each position. A register of practising certificates is maintained for all health professionals. The service has a role-specific orientation programme in place that provides new staff with relevant information for safe work practice and includes buddying when first employed. Competencies are completed at orientation. The service demonstrates that the orientation programme supports care and support staff to provide a culturally safe environment to Māori. Staff interviewed confirmed the orientation programme was adequate to familiarise themselves with their role, the facility, and the organisation. There is an

		appraisal policy in place, with all staff who have been employed for over one year are to have an annual performance appraisal completed however four out of the eight staff files reviewed did not have an up-to-date annual performance appraisal.
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	The organisation's admission and decline policy clearly outlines eligibility criteria, information requirements, and decision-making processes in accordance with organisational and ARRC contractual obligations. The clinical nurse manager oversees the admission process to ensure it is timely, competent, and equitable. A waiting list is maintained, and communication with prospective residents remains open. Entry and declined entry data are collected and analysed by head office to support service improvement and equity monitoring for Māori. The previous audit finding related to entry and decline data for Māori (criterion # 3.1.5) has been addressed.
Subsection 3.2: My pathway to wellbeing The people: I work together with my service providers so they know what matters to me, and we can decide what best supports my wellbeing. Te Tiriti: Service providers work in partnership with Māori and whānau, and support their aspirations, mana motuhake, and whānau rangatiratanga. As service providers: We work in partnership with people and whānau to support wellbeing.	FA	Seven resident records were reviewed: two rest home, three hospital (including one on ACC and YPD) and two at dementia level of care hospital (including one on respite care). Note the sample was extended with one file to include a hospital level resident on an ARRC contract. New admissions are admitted by the registered nurse on duty, and they complete all initial assessments including an initial care plan. The allocated keyworker completes all other documentation. The registered nurses are responsible for all resident's assessments, care planning, and evaluation of care. All initial assessments and long-term care plans were completed for residents, detailing needs, and preferences. The individualised electronic long term care plans (LTCPs) are developed with information gathered during the initial assessments and the interRAI assessment. All LTCPs and interRAI sampled had been completed within three weeks of the residents' admission to the facility. The YPD resident had an interRAI completed; for the residents on ACC and respite care an admission suite of assessments were completed to meet

		their medical, non-medical, cultural, and social needs. Assessments identified specific needs including (but not limited to) pressure injury prevention, mobility, and nutrition. The outcomes of risk assessments are considered when developing the care plan. Documented interventions and early warning signs (EWS) meet the residents' assessed needs and provided sufficient guidance to care staff in the delivery of care. The activity assessments include a cultural assessment which gathers information about cultural needs, values, and beliefs. Information from these assessments is used to develop the resident's individual activity care plan. Residents that exhibit behaviour including those in the dementia unit has a behaviour monitoring chart, behaviour assessment, and behaviour management plan in place with strategies to manage their specific behaviour over a 24-hour period. Short term care plans are developed for acute problems, for example infections, wounds, and weight loss. Resident care is evaluated on each shift and reported at handover and in the progress notes. Handover was witnessed and found to be comprehensive in nature. If any change is noted, it is reported to the registered nurse. Long-term care plans are formally evaluated every six months in conjunction with the interRAI re-assessments and when there is a change in the resident's condition. Evaluations are documented by the registered nurses and include the degree of achievement towards meeting the desired goals and outcomes. Residents interviewed confirmed assessments are completed according to their needs. There was evidence of family/whānau involvement in care planning and documented ongoing communication of health status updates. The service has policies and procedures in place to support all residents to access services and information. The initial medical assessment is undertaken by the general practitioner within the required timeframe following admission. Residents have ongoing reviews by the general practitioner within required timeframes and when their health status changes. There is one general practitioner (who has most residents under their care) who visits twice weekly and as required. Medical documentation and records reviewed were current. When interviewed the general

		practitioner was complimentary regarding the standard of care and clinical/operational leadership. After hours care is provided by the contracted medical practice. Physiotherapy referrals are activated as required and the physiotherapist is on site for eight hours a week. A podiatrist visits regularly. Other health professionals involved in the residents' care include a hospice nurse, speech and language therapist, dietitian, and older persons mental health team. An adequate supply of wound care products was available at the facility. At the time of audit there was one facility acquired suspected deep tissue injury, and a small number of minor wounds. The documentation (including the notification to HQSC) was reviewed. The wound care plan and progress notes evidenced regular assessment, review, and evaluation. Family/whānau had been kept updated as to the management and progress of this. Photos are taken when required and wound specialist advice is available by referral through to the Health New Zealand wound specialists. The progress notes are recorded and maintained in the integrated records. Monthly observations such as weight and blood pressure were completed and were up to date. Neurological observations are recorded following un-witnessed falls as per policy. A range of monitoring charts are available for the care staff to utilise. These include reposition charts, food and fluid management charts and monthly blood pressure, weight monitoring, and bowel records. Staff interviews confirmed they are familiar with the needs of all residents in the facility and that they have access to the supplies and products they require to meet those needs.
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	FA	There are policies available for safe medicine management that meet legislative requirements. All staff who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided as part of the competency process. Registered nurses have completed syringe driver training. Staff were observed to be safely administering medications. The registered nurse and medication competent healthcare assistants interviewed could describe their role regarding medication administration.

guidelines.		The service uses robotic rolls for medication. All medications are checked on delivery against the medication chart, and any discrepancies are fed back to the supplying pharmacy. Medications were appropriately stored in locked cupboards and the medication trolleys in the medication room. The medication fridge and room temperatures are monitored weekly as per the Medicine Management policy and procedures, and all stored medications are checked weekly for expiry dates. Eyedrops are dated on opening. Thirteen medication charts were reviewed. Each chart sampled had photographic identification and allergy status identified. Indications were used were noted for as required medications, and the effectiveness of as required medication was consistently documented. There were no residents self-administering medications. However, policy and procedures are available to guide staff should a resident wish to self-administer their medication in the future. No vaccines are kept on site. There are no standing orders in use. There was documented evidence in the clinical files that residents and relatives are updated around medication changes, including the reason for changing medications and side effects. When medication related incidents occurred, these were investigated and followed up.
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 services team leader interviewed explained how food preferences and cultural preferences are encompassed into the five-week seasonal menu. The kitchen receives notification of any dietary changes or updates to nutrition/dietary profiles for residents. The food services team leader demonstrated their access to the electronic nutrition/dietary profiles of each resident. Dislikes and special dietary requirements are accommodated, including food allergies. Residents and family/whānau interviewed confirmed the kitchen team accommodate residents’ requests. There is a verified food control plan current to 23 January 2027. The residents and family/whānau interviewed were complimentary regarding the standard of the meals served. Nutritious snacks were available 24/7.

Subsection 3.6: Transition, transfer, and discharge The people: I work together with my service provider so they know what matters to me, and we can decide what best supports my wellbeing when I leave the service. Te Tiriti: Service providers advocate for Māori to ensure they and whānau receive the necessary support during their transition, transfer, and discharge. As service providers: We ensure the people using our service experience consistency and continuity when leaving our services. We work alongside each person and whānau to provide and coordinate a supported transition of care or support.	FA	There were documented policies and procedures to ensure discharging or transferring residents have a documented transition, transfer, or discharge plan, which includes current needs, and risk mitigation. Planned discharges or transfers were coordinated in collaboration with the resident, family/whānau and other service providers to ensure continuity of care. When residents need or request services from other health professionals, a referral is completed. Any transfer to a higher level of care within the facility is coordinated with the input from the family/ whānau.
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.	PA Moderate	An emphasis has been placed on ensuring that the facility is home like for the residents. The plant and equipment are maintained through a regular planned maintenance programme and refurbishment of rooms as they become vacant. However, it was noted that the building warrant of fitness (BWOF) had expired in June 2025. The environment is inclusive of people's culture and supports cultural practices. There is an annual maintenance plan that includes electrical testing and tagging, equipment checks, call bell checks, calibration of medical equipment and monthly testing of hot water temperatures. Hot water temperature recording reviewed had corrective actions undertaken when outside of expected ranges. The manager explained that major remedial work has been 90 percent completed on the plumbing system and the boiler system to ensure that water temperatures are maintained. The water temperatures records reviewed evidence water temperatures are maintained. The last complaint related to hot water temperatures was documented in August 2025. The previous finding related to the hot water temperatures being outside of range (criterion# 4.1.1) has been addressed. Staff and residents interviewed stated the hot water temperatures improved. Essential contractors/tradespeople are available 24 hours per day as required.

Subsection 5.2: The infection prevention programme and implementation The people: I trust my provider is committed to implementing policies, systems, and processes to manage my risk of infection. Te Tiriti: The infection prevention programme is culturally safe. Communication about the programme is easy to access and navigate and messages are clear and relevant. As service providers: We develop and implement an infection prevention programme that is appropriate to the needs, size, and scope of our services.	FA	There is infection prevention, and antimicrobial policies and procedures that includes the pandemic plan. The programme is linked to the quality improvement programme and is approved by the governing body. A clinical coordinator leads the infection prevention programme and has input into infection prevention policy development, and review. Policies were developed with input from infection prevention specialists, and these comply with relevant legislation and accepted best practice. The infection prevention programme is reviewed annually. The pandemic plan is available for all staff. The infection prevention coordinator (who has had recent training around the infection control programme) is responsible for delivering infection education to health care and support workers. Infection prevention education is included within the staff orientation programme and the mandatory education schedule. Staff education includes standard precautions; isolation procedures; hand washing competencies; and donning and doffing of personal protective equipment (PPE).
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	The antimicrobial policy aims to provide a quality review of the incidents of infections, reduce the rate of infections within the facility and reinforce basic principles of infection prevention. Infection surveillance is the responsibility of the infection prevention coordinator (a registered nurse). The infection prevention coordinator outlined how the results of surveillance and any recommendations required to improve performance are shared with the governing body and relevant people where required. All infections are entered into the electronic resident system, with a monthly collation and analysis of infections completed by the infection prevention coordinator. Any trends are identified, and corrective actions implemented. The service incorporates ethnicity data into surveillance methods and data captured around infections. Outcomes are discussed at handovers when residents have infections and at staff meetings. Staff have received infection prevention related training including outbreak management. Internal infection prevention audits are completed with corrective actions for areas of improvement. The service receives regular notifications from Health New Zealand. The last Covid-

		19 outbreak was in March 2026. Residents and staff were affected. The outbreak was appropriately managed and documented.
Subsection 6.1: A process of restraint The people: I trust the service provider is committed to improving policies, systems, and processes to ensure I am free from restrictions. Te Tiriti: Service providers work in partnership with Māori to ensure services are mana enhancing and use least restrictive practices. As service providers: We demonstrate the rationale for the use of restraint in the context of aiming for elimination.	FA	The service aims for a restraint free service, and this is supported by the governing body and demonstrated within policies and procedures. There were no residents using any form of restraint at time of audit. The designated restraint coordinator is a clinical coordinator. Systems are in place to ensure restraint use will be reported to staff meetings, and to the PSC head office when required. Restraint policy confirms that restraint consideration and application must be done in partnership with residents and family/whānau and the choice of device must be the least restrictive possible. Elimination of restraint use is included as part of the education and training plan.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 2.2.2 Service providers shall develop and implement a quality management framework using a risk-based approach to improve service delivery and care.	PA Moderate	The resident and family/whānau satisfaction surveys were completed in September 2025. There were no documented corrective actions implemented around keys areas for improvement from the surveys. Monthly staff, quality, RN/clinical meetings are scheduled to provide an avenue for discussions in relation to quality data; health and safety; infection prevention; benchmarking (with other PSC facilities) complaints received; staff; and education. However, staff, quality, RN/clinical and resident meetings have not always been completed as per the annual schedule. Not all agenda items, discussion points and corrective actions have been documented, followed up, and signed off when completed. The shortfall identified at the previous audit	(i). Staff, quality, RN/clinical and resident meetings have not always been completed as per the annual schedule. Not all agenda items, discussion points and corrective actions have been documented, followed up, and signed off when completed. (ii). There were no documented corrective actions implemented around keys areas for improvement from completed the resident and family/whānau satisfaction surveys.	(i). Ensure that all staff, quality, RN/clinical and resident meetings are completed as per the annual schedule and all agenda items, discussion points and corrective actions are documented, followed up, and signed off when completed. (ii). Ensure that any required corrective actions are implemented and completed for the annual resident and family/whānau satisfaction surveys 60 days

		has not been addressed and the risk rating has been raised from low to moderate in this report.		
Criterion 2.3.4 Service providers shall ensure there is a system to identify, plan, facilitate, and record ongoing learning and development for health care and support workers so that they can provide high-quality safe services.	PA Low	There is an annual education and training schedule being implemented for 2026. The education and training schedule lists compulsory training required to be completed. Staff completion percentage rates for the mandatory and scheduled training topics including the aging process, code of rights, privacy/dignity, cultural safety, abuse/neglect, communication, pain management, restraint, and complaints management were low.	Staff completion percentage rates for the mandatory and scheduled training topics including the aging process, code of rights, privacy/dignity, cultural safety, abuse/neglect, communication, pain management, restraint, and complaints management were low.	Ensure that staff completion percentage rates for the mandatory and scheduled training topics are increased to the required level. 90 days
Criterion 2.4.5 Health care and support workers shall have the opportunity to discuss and review performance at defined intervals.	PA Low	There is an appraisal policy in place, with all staff who have been employed for over one year are to have an annual performance appraisal completed, however six out of the four staff files reviewed did not have a documented up-to-date annual performance appraisal.	Eight staff files were reviewed; four out of the eight staff files did not have a documented up-to-date annual performance appraisal.	Ensure that all staff who have been employed for over one year have an annual performance appraisal completed. 90 days
Criterion 4.1.1 Buildings, plant, and equipment shall be fit for purpose, and comply with legislation relevant to the health and disability service being provided. The	PA Moderate	The building warrant of fitness has expired (22 June 2025). The manager explains that all 12 A forms were completed in a timely manner; however, the Wellington Council stated the internal fire doors were not compliant according to specifications and therefore the BWOF was not issued. Due to the	The building warrant of fitness expired in June 2025.	Ensure the building has a current building warrant of fitness. 180 days

environment is inclusive of peoples' cultures and supports cultural practices.		major financial implications, there is a PSC national plan in progress to review and mitigate the risk.		

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.