



# **Final Inspection Report**

## **Experion Care NZ Limited - Wensley House**

**22 May 2023**

HealthCERT  
Quality Assurance and Safety  
Regulatory Services  
Manatū Hauora

## Table of Contents

1. Provider Details .....	3
2. Executive Summary .....	3
3. Background .....	3
4. Inspection Team .....	4
5. Inspection Methodology .....	4
6. Inspection Limitations .....	4
7. Entry Meeting .....	4
8. Inspection Findings .....	4
9. Summation Meeting .....	5

## 1. Provider Details

Certificate:	Experion Care NZ Limited - Wensley House
Premises:	Wensley House
Premises Address:	49 Wensley Road, Richmond, Nelson
Contact Person:	Owner of Experion Care New Zealand Limited – [REDACTED]
Internal Ref:	PRMS_Audit_000030026001
Inspection Date:	22 May 2023

## 2. Executive Summary

This unannounced inspection was undertaken on 22 May 2023 at Wensley House (49 Wensley Road, Richmond, Nelson).

The inspection was undertaken to determine if the services being provided met the Ngā paerewa Health and disability services standard (NZS8134: 2021) (Ngā Paerewa). The inspection was completed by Manatū Hauora (the Ministry of Health) in accordance with sections 40, 41 and 43 of the Health and Disability Services (Safety) Act 2001 (the Act) to determine if health care services are being provided in compliance with Section 9 of the Act.

The focus of the inspection was to consider aspects of the quality and risk framework, determine whether clinical care and environment was being provided to the required standard following ongoing complaint activity. The 2022 certification audit corrective action progress was also followed up following concerns that the evidence provided previously was insufficient. The inspection included review of resident files, review of the quality and risk system in place, interviews with the owner, staff and residents and a resident advocate of Wensley House, suppliers of services to the facility, a review of the premises, policy and procedure documentation and included review of Human Resource (HR) records.

Based on the evidence, Experion Care NZ Limited (Wensley House) did not fully comply with 13 subsections of Ngā Paerewa. The partially attained subsections relate to: complaint management, governance, the quality and risk framework, adverse event reporting, human resource management, staff training, assessment, planning, evaluation and GP reviews of medication.

Despite the resulting corrective actions, it is important to mention the residents reported being happy at the facility. It is also relevant to add that the issues identified in this report are not exhaustive of the improvements required at Wensley House.

Ongoing monitoring will be undertaken by HealthCERT.

## 3. Background

**Law:**

Providers of health care services must be certified by the Director-General of Health (Sections 9(a) and 26 of the Act) and must comply with all relevant Health and Disability Service Standards (Section 9(b)).

The relevant service standards are approved under the Health and Disability Services (Safety) Notice 2008. The standard approved is the Ngā Paerewa Health and Disability services standard NZS 8134:2021.

## **Facts:**

### **a) Governance**

Wensley House is located in Richmond, Nelson and is certified for rest home level care with a 30-bed capacity in the care home and 13 serviced apartments certified for rest home level of care. Experion Care have owned Wensley House since 2017.

The rest home is currently under temporary management with a temporary manager having been assigned to Wensley House by Te Whatu Ora Health New Zealand Nelson Marlborough (Te Whatu Ora) in March 2023. Earlier in 2023 following complaints and concerns about the standard of care being delivered to residents, Te Whatu Ora placed an experienced aged care consultant in Wensley House to support the then General Manager (GM). Admissions to the facility were stopped at this time and have not resumed as yet. During the first two months with the consultant there were minimal changes made to improve the service by the GM resulting in the GM being removed by Te Whatu Ora under clause A22.2 of the Aged-Related Residential Care Services Agreement and a temporary manager put in place. Wensley House was also in breach of the Age-Related Residential Care Services Agreement with Te Whatu Ora at this time under clauses A2.1, A4.1 and D5.4

The owner, the temporary manager and the consultant were all able to provide information, evidence and discussion to the inspection.

On the day of the inspection, there were 26 residents in the facility.

At the time of the inspection the temporary manager was the only registered nurse (RN) working at the facility.

Previously the GM, who was also a RN was supported by a casual RN who had worked up to four days a week to support the GM. The RN resigned following the general managers resignation. It appears that the GM practised in isolation and communication with the owner was via Zoom or telephone, as the owner states he operates remotely spending six months of the year overseas. There was also no obvious communication with other GMs in the other facilities owned by Experion care.

No evidence of clinical governance was able to be provided. Certified aged residential care services are primarily led by RN's and as such it is reasonable to expect evidence of clinical leadership and governance within an organisations structure. There was no evidence of communications between the owner and the GM found at the facility to determine the content and extent of communications between the GM and the owner.

Ngā Paerewa requires that governance bodies shall actively engage with the service providers and monitor, review and evaluate performance. There was no evidence found to support that these requirements were being met. The owner on interview was not aware of

all the obligations under the Governance Subsection (2.1 of Ngā Paerewa). The organisation currently does not appear to meet many of the criteria related to governance.

A recently appointed RN was due to commence employment the day following the inspection and a recently appointed GM is due to commence on 1 June 2023. The Te Whatu Ora appointed temporary manager is due to leave Wensley House on the 7 July 2023.

Follow up on certification audit 2022 - corrective action progress - Criterion 2.1.2. - Governance bodies shall ensure service providers' structure, purpose, values, scope, direction, performance, and goals are clearly identified, monitored, reviewed, and evaluated at defined intervals.

- Much of the evidence stated by the previous GM to have been supplied to South Island Alliance Programme Office (SIAPO) was unable to be located at the SIAPO office or at Wensley House. The Wensley House Business, Quality Risk and Management Plan 2022- 2023 was submitted to SIAPO; however, no evidence was supplied of monitoring of the plan and some of the information related to the 2018 and 2019 plans and the tasks were noted to be performed by staff who were never employees at Wensley House such as enrolled nurses (EN). No progress on the list of tasks was documented.

## **b) Quality and Risk Management Systems**

A comprehensive review of the provider's quality and risk system was to be undertaken during the inspection, however, there was very little evidence of a quality and risk management system in place.

Since 2017 Wensley House has received 14 corrective actions following audits related to the Quality and Risk management system with many being recurring issues and a number of them being rated as high and moderate risk.

Despite the first goal in Wensley Houses business plan being continuous quality improvement, there is a lack of evidence of any continuous improvement activity. A quality improvement plan that is implemented and evaluated with corrective actions arising when required is a contractual requirement under clause D19.4 of the Age-Related Residential Care (ARRC) Services Agreement.<sup>1</sup>

The hazard register sited was not an active register relevant to Wensley House, it comprised of a list of generic hazards that could relate to any aged care facility at any one time.

There was no evidence of quality improvement activity within the facility.

Follow up of certification audit 2022 - corrective action progress - Criterion 2.2.3 - Service providers shall evaluate progress against quality outcomes.

- Evidence was provided by the previous GM to SIAPO of corrective action plans being developed, implemented and evaluated following outcomes from internal audits; however, during the inspection there was no evidence to support that what had been sent to SIAPO was a true and accurate record of these actions.

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<sup>1</sup> Age-Related Residential Care Services Agreement D19.4.

- Hard copy policies were located in various places throughout the facility in multiple folders. All documents sighted were not document controlled, most were not dated nor individualised to the facility and there were obviously different versions of the same policy in different folders. On discussion with staff, some had not seen or been notified of the folders with the various policies within, plus it was discovered that an online 'dropbox' containing policies and procedures was unable to be accessed by staff for a variety of reasons, the main one being the inability for staff to download the documents in a timely manner, due to the inadequate information technology structure within Wensley House.<sup>2</sup> The dropbox documents are not easy to navigate and it would be difficult for many of the staff to access and locate the appropriate document. The documents in dropbox have the Experion Care logo in the header; however, the hard copy documents sighted at Wensley House did not have the organisation logo on them. An example of this is the review and amendment log dated May 2022 where it states the QA manager or designated person updates the manual contents. At the time of this inspection there was not a QA manager in place at Experion care. The owner reported at the inspection that a Quality person has now been appointed for two days a week for the organisation commencing in the next month.
- A communication book had been in place, but it was noted there had been minimal use. The temporary manager has commenced a new communication book and there was evidence of important information being shared with the team.

### c) Complaint Management

Complaint management was of a very poor standard. The Te Whatu Ora appointed consultant has endeavoured to implement a system of recording complaints and the management of the same; but it is in its infancy. There was no systematic way of capturing complaints and the registers that were found did not record all elements that would be expected to be seen in a complaint register. Very little evidence was documented as to an investigation occurring, whether the required timelines were met and whether outcomes were reported back to the complainant. Recent complaints that had been raised with Manatū Hauora and Te Whatu Ora were not documented on any of the registers sighted, so it was impossible to determine if the complaints had reached a resolution, whether discussion with staff had occurred and any learnings learnt. No corrective action process was in place. Wensley House is currently in breach of Right 10 of the Code of Health and Disability Services Consumers' Rights (the Code) and Subsection 1.8 of Ngā Paerewa, I have the right to complain is not being met.

The complaint received by HealthCERT in December 2022 from ██████ described many areas where care had been perceived to be substandard, such as unable to have vegan food, sharing of the residents' inhaler with other residents, lack of care following a fall. This complaint also raised issues of disrespecting the residents' belongings following their death. The family had been told by the GM that Manatū Hauora had pressured the family into clearing the room, this is an assertion that is believed to be false.

The complaints policy was on display at the entrance to the facility along with information about the Nationwide Health and Disability Advocacy Service; however, these were "tired looking" documents and the Code of Rights poster on display was a version that has long been superseded.

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<sup>2</sup> Whilst the inspection was occurring some of these issues were being addressed. A new Wifi system was installed.

These issues around complaint management have been recurring findings at audits since February 2019.

Follow Up on certification audit corrective action progress - Criterion 1.8.2 - I shall be informed about and have easy access to a fair and responsive complaints process that is sensitive to, and respects, my values and beliefs.

- The evidence that was stated to have been provided by the previous GM to SIAPO, was not found at the facility nor in the SIAPO office. The complaint and meeting minutes documented as being sent were over a year old and so did not demonstrate current practice.

#### **d) Adverse Event Reporting**

Thirty-five incident forms were reviewed, mostly related to resident falls. The quality of the documentation was variable and the most common theme being 'serial faller'. There was no evidence to suggest that the incidents were investigated to find the cause of the fall, resulting in no prevention strategies being put in place to prevent further falls. There was also a lack of a clinical assessment of the resident post fall. Any information about the actions needing to be completed post fall was not evident on the incident forms circulating at Wensley House. Trending of incidents was not evident and no evidence of competency training for staff regarding falls management was found. Within the incident file, two incident forms were cited relating to missed doses of medications, the medication blister packs were attached to the forms with the medications still inside the pack. This is not best practice and carries a risk, as the forms are not in a secure location.

A review of the incident / events policy was undertaken and it was clearly evident that Wensley House did not comply with Experion Care's own policy nor statutory and regulatory obligations in relation to essential notifications and breaches under the ARCC agreement clause D19.3. The policy did not use easy to understand English and there were no definitions to the abbreviations and terms used within the policy.

Follow up on certification audit corrective Action Progress - Criterion 1.6.3 My service provider shall practise open communication with me.

Some evidence that was stated to have been provided by the previous GM to SIAPO such as the adverse event and open disclosure policies were provided; however, copies of the team health and safety infection control meeting minutes demonstrating that incidents and open disclosure had been discussed were unable to be found in the SIAPO office or at Wensley House.

#### **e) Human Resource Management**

Six staff files were reviewed and these were of variable consistency of data. Of the six files only one had evidence of police vetting. The temporary manager is currently going through the process of police vetting for all staff. The Wensley House policy related to this is somewhat ambiguous stating it is at the manager's discretion; however, it is well recognised in New Zealand that the elderly are vulnerable and must be protected and police vetting of all staff is considered standard practice in Aged Care. Not all records had evidence of reference checks being undertaken, performance appraisals, position descriptions and individual employment agreements (IEA). The signed IEAs did not

always contain the employer and employee signatures. Evidence of orientation was not evident in all records. There was evidence of training in long standing employees records but minimal in others. The staff records sighted did not comply with criterion 2.4.1 of Ngā Paerewa.

Staff training corrective actions for multiple criteria have appeared on every audit report undertaken at Wensley House since Experion Care took ownership, many of which are recurring. First aid training is currently being organised by the temporary manager to enable Wesley House to meet the requirement to always have a staff member with a current first aid certificate on site at all times. Many of the staff have received minimal training and the training records sighted and sent to SIAPO as evidence of attendance were not robust in guaranteeing that the person had attended the training, with attendance evidenced by a tick appearing to have been written by the same person. The owner during interview described having access to an e-learning training module that other sites used. Following discussion with some staff it was felt that this was unrealistic for the staff at Wensley House to use this methodology for training as

- a) the modules took a long time to download due to the status of information technology platform,
- b) Only minimum staff are rostered on, so time does not allow for staff to complete any modules during work hours, and
- c) staff were unclear if payment would be received for completing the module out of work hours.

The owner did state during the closing meeting that staff would be recompensed for undertaking training in their own time. Currently Wensley House does not comply with Experion Care's own Training Policy document in Dropbox.

Follow up of certification audit corrective action progress – 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.

- The education planner submitted by the previous GM to SIAPO was not found in the facility on the day of the inspection, different iterations of training plans were found; however, evidence of the training actually occurring was not found. It has become evident to the temporary manager that little training has taken place. Training/ education sessions have been organised over the next few months. Evidence of staff training sheets in personnel files was inconsistent. Annual medication competencies had not been completed and staff were unaware that this was a requirement, however, the temporary manager has carried out medication competencies for a number of staff since commencing the role.

#### **f) Service Provider Availability**

This was not reviewed in great detail at the inspection; however, there were some areas of concern that were raised during the day of the inspection and discussion with other service providers who deliver services to Wensley House post inspection.

Lack of physiotherapy input – it would appear from reviewing the incident reports that a physiotherapist would be of benefit to Wensley House in particular to monitor the

'serial faller' residents. It would also ensure that Wensley House would meet the ARCC agreement related to providing services that are comprehensive and multidisciplinary.

Discussion with general practitioners and pharmacists who visit the facility discussed having times when they are not fully recompensed in a timely manner for services delivered. At the time of the inspection there was no contract in place for the pharmacy services however, on discussion with the pharmacist the following day they stated they were going in that day to sign an agreement with Wensley House.

There appears to have been issues over the years with general practitioner visits. These varied in nature, but two key themes arose from the discussion, one was financial payments not being made in a timely fashion and not always the entire amount each month, and the other was communication. One practice discussed how they stopped visiting the facility due to not being paid in full each month for services delivered and would only come if requested for an emergency. Evidence was provided to the inspector by the director of Experion demonstrating that this issue was an account reconciliation issue and not a non-payment issue.

Evidence was sighted when reviewing resident's clinical records of an absence of general practitioner (GP) reviews for many months, far exceeding the requirement of the ARCC agreement hence Wensley House breaches this agreement. One GP discussed having a trust issue with the previous GM as they had not always been told the truth about a resident's condition, plus residents recently had been admitted to the facility that were beyond the ability of the home to care for and which had also impacted on the GPs. Offers of help were given to the previous GM to try and set up a system to triage residents to enable them to make decisions about the urgency of visiting however, this never got off the ground. Two medical centres discussed how residents were often taken to the emergency department without any prior discussion with a GP. The temporary manager was currently rebuilding the relationships with GPs.

Follow up on certification audit corrective action progress - Criterion 3.4.2 - The following aspects of the system shall be performed and communicated to people by registered health professionals operating within their role and scope of practice: prescribing, dispensing, reconciliation and review.

- Copies of electronic medication charts were submitted to SIAPO demonstrating that medication charts were current and evidenced the date of the last GP review – all were within date, however, it is evident that this may not have been representative of all residents' records as GPs discussed with the inspector that they had not been attending three monthly to undertake these reviews.
- Staff often drove residents to the GPs practice or took residents directly to the emergency department prior to being appropriately assessed. The GM previously told staff not to call an ambulance but for them to drive unwell residents to either place. This should have been an area of concern for the company and raises issues of high risk such as: what if there had been an accident enroute, what if the resident became critically unwell and if this had been on an afternoon or night shift it would have left one member on their own in the facility. The temporary manager has ceased this practice.

### **g) Pathways to Wellbeing**

The inspection team reviewed six resident's clinical records. They were consistently

incomplete. A paper-based system is in use. There was some discussion about Experion Care purchasing an electronic patient management system in the future and this was encouraged. The review identified:

- risk assessments, InterRAI assessments and reassessments were not completed in a timely manner, if at all
- care plans were not updated in a timely manner and therefore if the residents' needs had changed, they were not always receiving the required care
- only one service agreement was sighted in the clinical files reviewed, meaning Wensley House is in breach of the ARRC agreement. There was no evidence sighted elsewhere in the facility of signed service agreements.
- consents were not always signed where required
- no apparent consideration of prevention strategies for frequent faller/s or residents with behavioural issues.

Follow up on certification audit corrective action progress – Criterion 3.2.1 and Criterion 3.2.5 - refer to standard for criteria information.

- These criteria relate to residents' initial assessments and care plans not being completed and not undertaking planned review of care plans along with updating care plans as the residents' condition change. The review of the six resident clinical records as described above demonstrate that these issues still remain.

### **Note**

- Wensley House currently have a cohort of residents who are mostly independent and require minimal assistance; however, they have vulnerabilities which require and are deserving of high-quality care. The current cohort of residents is a positive for the facility and is preventing exposure to risk both for the residents and the facility. Currently there is a halt on resident admissions and this seems appropriate until the facility can improve its service management, RN coverage and staff training. Last year the facility admitted residents without assessing them and was then not able to provide the level of care the residents required. These residents have now all been placed in a more appropriate level of care facility. All residents interviewed were happy at Wensley House and some referred to it as home.
- Previously due to the inadequate technology network within the facility, staff members were using their own email to discuss resident cares which meant that the resident information was not secure or private and the information shared was not integrated into the residents' clinical record. This does not comply with criteria 2.5.1 and 2.5.2 of Ngā Paerewa. The temporary manager was addressing this issue at the time of the inspection.

### **h) Medication Management**

Policies and procedures were reviewed. Again, there was evidence of the documents not being individualised to Wensley House. It is recommended that this is undertaken and documents that are not pertinent to the facility be removed.

The medication folder contained many documents including but not limited to guidelines for medication administration, the use of medimap, controlled medicines management and pain management which are all useful to guide staff. A medication round was undertaken with the care giver who has undertaken medication competency, and this was completed correctly with the care giver demonstrating a good understanding of the process.

Discussion with the temporary manager highlighted another high-risk concern that had been in practice until stopped by the temporary manager recently and this involved the cleaner regularly collecting Methadone from a local pharmacy.

Reviewing of the incident reports and discussion with the temporary manager also highlighted that pro re nata (PRN) medications were being given to control people's behaviour, not to treat a mental illness or physical condition. This highlighted the staff administering PRN medications lack of understanding of PRN medication management and inadequate medication competency oversight. The facility and/ or staffing levels do not lend themselves to finding a quiet area to deescalate a resident's behaviour; however, the temporary manager has made a space, and implemented a PRN log book requiring two staff sign out for PRN medications, to ensure the reduction in the use of chemical restraint which is no longer acceptable practice in New Zealand.

Follow up on certification audit corrective action progress – Criteria 3.4.4 and 3.4.6 - related to recording allergies or sensitivities and residents who self-medicate have a competency review undertaken. These have been addressed since the temporary manager has been at Wensley House.

#### **i) Person Centred and Safe Environment**

The facility is old; however, it was clean and uncluttered on the day of the inspection. There is a maintenance person who also undertakes carers duties at times. The outside was tidy. The building warrant of fitness had expired (five days earlier) but on the day of the inspection there was activity underway by the various workmen to fulfil the obligations to obtain a new building warrant of fitness.

There are areas that require attention to ensure it meets infection prevention standards. In particular the sluice areas require attention. It is fortunate currently that all the residents are continent and do not use equipment to assist with meeting their toileting needs.

The laundry area has improved in the last few months with a system having been established with different bags for different laundry items rather than the previous one bag for all. Carers undertake the laundry however, there was no evidence of them having received training on this. A new washing machine has recently been purchased as well as a tag naming machine so all resident clothes can be clearly labelled. Safety data sheets were in place. In the last month a cleaning schedule has been introduced which has assisted the cleaner with their tasks and ensures a clean facility. There is a locked cupboard where cleaning materials are stored. Linen cupboards were tidy having recently had copious amounts of extra linen removed, this excess was cited in the upstairs cupboard.

The kitchen, however, was not clean, it was untidy and had areas where plugs were loaded into one power board that was hanging alongside a Bain Marie. Food items were stored correctly and dated on opening. As yet there continues to not be a food

control plan in place, this is a long-standing corrective action. Refrigerators required cleaning and defrosting, and cupboards and other storage areas required cleaning.

## **4. Inspection Team**

The inspection was undertaken by Chris McLelland, Senior Advisor, HealthCERT, Jo Noble, Principal Advisor, HealthCERT, Ministry of Health, under delegated authority of the Director-General of Health.

## **5. Inspection Methodology**

The following methodology was used during the inspection:

- Interview with Director, temporary manager, staff, contractors and Te Whatu Ora Health of Older Persons portfolio manager
- Observation of residents
- Physical inspection of premise / equipment
- Review of Clinical Records
- Review of policies and procedures.

## **6. Inspection Limitations**

The scope of the inspection was primarily limited to the quality and risk management system, clinical care of residents and training and orientation of staff. Other aspects such as progress on previous corrective actions have been considered where resident outcomes may have been impacted.

## **7. Entry Meeting**

On arrival at the premises, Wensley House, Chris McLelland, Senior Advisor, HealthCERT, and Jo Noble, Principal Advisor, HealthCERT, met with the temporary manager.

The purpose of the visit was explained, and a letter addressed to the Owner outlining the reason for the inspection and the authorisation to undertake the unannounced visit was given to the temporary manager. The director was then rung and explained as to the visit and on arrival to the facility he was also given a copy of the authorisation letter. A copy of the Director-General of Health's delegation was shown to the temporary manager and the Director and it was explained how the inspection would be undertaken.

## **8. Inspection Findings**

Findings have been reported against the Ngā paerewa Health and disability services standards NZS 8134: 2021:

<b>Relevant subsection (code)</b>	<b>Finding</b>	<b>Corrective Action</b>	<b>Rating and timeframe</b>
<p>HDSS.2021:1.8 I have the right to complain</p>	<p>There was minimal evidence of a complaints process in place. On site two complaint registers were sighted, neither complete nor demonstrating all the requirements required of a complaints register. There was a lack of evidence of investigation, communication with the complainant and no timelines documented to meet Right 10 of the Code.</p> <p>No outcomes or corrective action plans were developed related to the complaint; therefore, it was unclear if any learnings had been gained from the documented complaints. It was evident that not all complaints that the facility was aware of, were documented in the registers sighted.</p>	<p>Ensure that a robust complaints process is implemented and that it meets the expectations of the Code of Health and Disability Services Consumers' Rights.</p>	<p>PA high 60 days</p>
<p>HDSS.2021:2.1 Governance</p>	<p>The governance body demonstrated a lack of governance to ensure compliance with regulatory and contractual requirements.</p> <p>There was a document which stated the business plan for Wensley House; however, this was not individualised to Wensley house and did not state objectives as to how they were going to achieve the generic goals. There was no evidence cited as to the monitoring of these goals by the governance body and no Key Performance Indicators (KPI's) were</p>	<p>Develop processes to ensure monitoring of Wensley House operational practices to ensure they meet all necessary requirements.</p> <p>Develop processes to monitor performance to ensure the facility is meeting its own goals and those of Experion Care.</p> <p>Provide documentation to support the appointment of the newly appointed facility manager.</p>	<p>PA high 90 days</p>

Relevant subsection (code)	Finding	Corrective Action	Rating and timeframe
	<p>sighted. There was no discussion whilst onsite to convince the inspector that this monitoring was indeed undertaken.</p> <p>Experion care were aware that the facility was not performing to a high standard and had previously had concerns raised about the previous general manager, but no ongoing monitoring appears to have occurred. A new facility manager has been appointed but as of the time of writing the report the owner has not provided the information requested to demonstrate that a robust appointment process had occurred.</p> <p>No evidence was cited to demonstrate how the governance body monitors performance of the Quality and Risk management system and instigates actions when required. The owner had received Treaty of Waitangi Training previously but was not up to date with Te Tiriti and the requirements of this criterion and the requirements of Ngā Paerewa.</p> <p>There is no clinical governance structure in place at Wensley House and Experion Care.</p>	<p>The governance body proactively monitors the quality and risk management system. The governance body to undertake Te Tiriti, health equity and cultural safety training and education to enable them to demonstrate expertise.</p> <p>Implement a clinical governance structure.</p>	
HDSS.2021:2.2 Quality and risk	There is no quality and risk management system evident at Wensley House. This is also a requirement	Implement a quality and risk management system.	PA high 90 days

Relevant subsection (code)	Finding	Corrective Action	Rating and timeframe
	<p>under clause D19 of the Age-Related Residential Care Services Agreement.</p> <p>Policies and procedures were not readily available to staff, were not individualised to Wensley House and were not document controlled.</p> <p>Various versions of the same policy were seen in folders around the facility. On review of incident forms, it was evident that these were not always fully completed. They lacked information about family/whānau notification, clinical assessment and there was no follow through with outcomes or minimisation of recurring risk and quality improvement.</p>	<p>Implement a document control system that is user friendly for staff and is document controlled.</p> <p>Ensure all incident/accident forms are completed and integrated into the quality and risk management system.</p>	
<p>HDSS.2021:2.3 Service management</p>	<p>Minimal evidence of training occurring for all staff was sighted. A training plan had been submitted to SIAPO in response to the corrective action raised at the last audit; however, there was no evidence that the training had actually taken place. The evidence submitted that staff had attended this training was not robust, a tick against the staff members name does not provide evidence that the staff member did attend and there was no evidence on site to support the documentation submitted to SIAPO.</p> <p>Sessions had not been</p>	<p>Implement a training/education plan to meet the needs of Wensley House staff.</p>	<p>PA moderate 90 days</p>

<b>Relevant subsection (code)</b>	<b>Finding</b>	<b>Corrective Action</b>	<b>Rating and timeframe</b>
	<p>recorded in staff members records when they had attended the alleged training. Training has been a recurring corrective action over previous audits.</p> <p>Staff interviewed were not aware that medication competency training was an annual requirement; hence this had not been undertaken for those who undertook medication administration. These training requirements are also required under Age-Related Residential Care Services Agreement D17.5 and D17.7.</p> <p>The temporary manager has been undertaking some training and organised for further training over the next few months.</p>		
<p>HDSS.2021:2.4 Health care and support workers</p>	<p>Six staff records reviewed demonstrated that good employment practices were not in place, only five records had individual employment agreements and job descriptions, none had police vetting, only one record had evidence of a reference check being undertaken and only three had performance appraisals. Performance Appraisals are a requirement of Age-Related Residential Care Services Agreement D17.6.</p> <p>Evidence of orientation occurring was cited for three out of the six records reviewed.</p>	<p>Good employment practices will be implemented to meet the requirements of the standard.</p>	<p>PA moderate 90 days</p>

Relevant subsection (code)	Finding	Corrective Action	Rating and timeframe
	Evidence was requested to be provided on the process for the last two employees appointed – a registered nurse and a new facility manager; however, these have not been provided.		
HDSS.2021:3.2 My pathway to wellbeing	<p>Six resident clinical records were reviewed: Findings were Risk assessments, InterRAI assessments and reassessments were not completed in a timely manner, if completed at all.</p> <p>Care plans were not updated, consents when required were not signed by the resident, prevention strategies were not implemented where required and of the six records only one service agreement was sighted.</p> <p>These findings demonstrate that the facility does not meet Ngā Paerewa and also does not meet the requirements of Age - Related Residential Care Services Agreement D13.1, D15A.1, D16.3, D16.4A, D16.5.</p>	Ensure assessments, care plans, interventions, re-assessments and evaluations are comprehensive, are undertaken in a timely manner and are current, reflect the needs of the residents and promote continuity of service delivery.	PA moderate 90 days
HDSS.2021:3.4 My medication	Evidence stated as being provided to SIAPO to meet this corrective action from the previous audit, that GP reviews were not being undertaken three monthly, could not be located either at Wensley House or in the SIAPO office. GPs spoken with acknowledged that they were not meeting this	Implement a system to ensure all residents medication records are reviewed at least three monthly by the GP.	PA moderate 90 days

Relevant subsection (code)	Finding	Corrective Action	Rating and timeframe
	<p>requirement due to the ongoing difficulties working with this facility.</p> <p>This finding demonstrates that the facility does not meet the standard and also does not meet the requirements of Age - Related Residential Care Services Agreement D16.5 e. ii.</p>		

## 9. Summation Meeting

Present: Chris McLelland, HealthCERT, Jo Noble, HealthCERT, Director, Experion Care Ltd, Portfolio manager of Older Persons Health, Temporary Manager and the contracted Consultant.

Chris McLelland thanked the facility for their participation and approach to the investigation recognising that this was an unannounced inspection. It was explained that a full summation of findings could not be provided at the closing meeting as information gathered needed further analysis. The provider was advised that this investigation report would be published on the Ministry of Health website.

### Key Issues raised at the summation were:

- Lack of quality and risk management system in place, including clinical review
- Lack of evidence that open disclosure always occurs, incident reporting sub optimal and that it was evident that chemicals were used to manage behavioural problems
- Very poor management of complaints with no consistent process in place
- Section 31 reporting not meeting legislative requirements
- Poor levels of staff training, staff records incomplete and e-learning module that owner discussed was not an appropriate tool to be used at Wensley House currently
- Inadequate staff records and Human resource processes
- Kitchen unhygienic
- Lack of Allied health involvement
- GP medication and resident reviews in breach of the ARCC agreement
- Lack of agreement in place with Pharmacy.

## 10. Conclusion

Under Section 9 of the Act, certified providers must meet all relevant standards and comply with any conditions subject to which the provider was certified by the Director-General of Health. Experion Care New Zealand Limited is required to undertake the following corrective actions within the specified timeframes. If the corrective actions are not

adequately addressed within the timeframes stated, it is likely that Manatū Haoura will take action in relation to non-compliance with the requirements of the Act.