Terrace View Lifecare Limited - Terrace View Retirement Village

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

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

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

The specifics of this audit included:

Legal entity:	Terrace View Lifecare Limited
Premises audited:	Terrace View Retirement Village
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 13 March 2025 End date: 13 March 2025

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 50

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

Terrace View Retirement Village (Terrace View) provides rest home and hospital level care for up to 64 residents. The service is operated by Terrace View Lifecare Limited and managed by the facility manager, who has been in the role since 1 May 2023. This person, previously employed as the maintenance manager for 10 years, is supported by the clinical nurse manager (CNM), who had been in the role for two weeks at the time of audit. The CNM is supported by an experienced registered nurse in the role of unit coordinator. There have been no changes to the facility or services provided since the last audit.

This surveillance audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, whānau, managers, staff, contracted allied health providers and a general practitioner.

Strengths of the service include the well-kept facility and landscaped grounds and the satisfaction of residents with the care provided. Two corrective actions required from the previous audit, related to the timeliness of care planning and infection surveillance, have not been fully addressed and further improvement is required. As a result of this audit, areas requiring improvement were identified relating to clinical governance, quality and risk systems, education and training, assessment and care planning, medication management and infection prevention.

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.

Terrace View works collaboratively to support and encourage a Māori world view of health in service delivery. There are systems and processes in place to support any Māori who enter the service to ensure Māori are provided with equitable and effective services based on Te Tiriti o Waitangi and the principles of mana motuhake.

Pacific peoples are provided with services that recognise their worldviews and are culturally safe.

Residents and their whānau are informed of their rights according to the Code of Health and Disability Services Consumers' Rights (the Code) and these are upheld. Service providers maintain professional boundaries and there was no evidence of abuse, neglect, discrimination or other exploitation. The property and finances of residents were respected.

Policies and the Code provide guidance to staff to ensure informed consent is gained as required. Residents and whānau felt included when making decisions about care and treatment.

Complaints are resolved promptly, equitably and effectively in collaboration with all parties involved.

Hunga mahi me te hanganga | Workforce and structure

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

The governing body assumes accountability for delivering a high-quality service. This includes ensuring compliance with legislative and contractual requirements, supporting quality and risk management systems, and reducing barriers to improve outcomes for Māori.

Planning ensures the purpose, values, direction, scope and goals for the organisation are defined. Performance is monitored and reviewed at planned intervals.

Clinical governance policies are in place to meet the needs of the service.

The quality and risk management systems are focused on improving service delivery and care using a risk-based approach. Actual and potential risks are identified and mitigated.

The National Adverse Events Policy is followed, with corrective actions supporting systems learnings. The service complies with statutory and regulatory reporting obligations.

Staffing levels and skill mix meet the cultural and clinical needs of residents. Staff have the skills, attitudes, qualifications and experience to meet the needs of residents. A systematic approach to identify and deliver ongoing learning and competencies supports safe equitable service delivery.

Professional qualifications are validated prior to employment. Staff felt well supported through the orientation and induction programme, with regular performance reviews implemented.

Ngā huarahi ki te oranga | Pathways to wellbeing

Includes eight subsections that support an outcome where people participate in the development of their pathway to wellbeing, and receive timely assessment, followed by services that are planned, coordinated, and delivered in a manner that is tailored to their needs.		Some subsections applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

The service works in partnership with the residents and their whānau to assess, plan and evaluate care. Care plans were based on comprehensive risk-based assessments and accommodated any new problems that arose. Files reviewed demonstrated that care met the needs of residents and whānau and was evaluated on a regular and timely basis.

Medicines are administered by staff who are competent to do so.

The food service meets the nutritional and cultural needs of the residents. Food is safely managed, supported by an approved food control plan.

Residents are referred or transferred to other health services as required.

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

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

The facility, plant and equipment meet the needs of residents and are culturally inclusive. A current Building Warrant of Fitness and planned maintenance programme ensure safety. Electrical equipment is tested as required.

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

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

A documented infection prevention (IP) programme has been developed by those with IP expertise and is linked with the quality improvement programme.

Staff demonstrated good principles and practice around infection control, supported by relevant IP education.

The 'Surveillance of health care-associated infections' programme is appropriate to the size and setting of the service, using standardised surveillance definitions, with an equity focus.

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 is a restraint-free environment. This is supported by the governing body and policies and procedures. There were no residents using restraint at the time of the audit. Staff have been trained in providing the least restrictive practice, de-escalation techniques, alternative interventions, and demonstrated effective practice.

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	11	0	6	1	0	0
Criteria	0	39	0	9	1	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	Terrace View has developed policies, procedures and processes to embed and enact Te Tiriti o Waitangi in all aspects of its work. Mana motuhake is respected. Partnerships have been established with cultural advisors from the local marae to support service integration, planning, equity approaches, and support for Māori. There were no residents and no staff at the time of audit who identified as Māori. The facility manager (FM) reported, and staff confirmed, they have attended cultural safety training. Staff reported they have attended Treaty of Waitangi training. Training records were not available on the day of the audit and the provider was unable to evidence the required training had been completed (refer 2.3.4).
Subsection 1.2: Ola manuia of Pacific peoples in Aotearoa The people: Pacific peoples in Aotearoa are entitled to live and enjoy good health and wellbeing. Te Tiriti: Pacific peoples acknowledge the mana whenua of Aotearoa as tuakana and commit to supporting them to achieve tino rangatiratanga. As service providers: We provide comprehensive and	FA	Terrace View works to ensure Pacific peoples' worldviews, cultural and spiritual beliefs are embraced. Staff reported at interview that they are guided to deliver safe cultural and spiritual cares to all residents through their knowledge and in the care plan. For example, food preferences, care planning and attending church services. There were two residents and no staff who identified as Pacific people on

equitable health and disability services underpinned by Pacific worldviews and developed in collaboration with Pacific peoples for improved health outcomes.		the day of the audit. A culturally safe care policy and procedure has been developed with input from cultural advisers that documents care requirements for Pacific peoples to ensure culturally appropriate services. Terrace View has links with the Pacific community. Staff reported they have attended cultural training. Training records were not available on the day of the audit and the provider was unable to evidence the required training had been completed (refer 2.3.4).
Subsection 1.3: My rights during service delivery The People: My rights have meaningful effect through the actions and behaviours of others. Te Tiriti:Service providers recognise Māori mana motuhake (self-determination). As service providers: We provide services and support to people in a way that upholds their rights and complies with legal requirements.	FA	Staff interviewed understood the requirements of the Code of Health and Disability Services Consumers' Rights (the Code) and were observed supporting residents in accordance with their wishes. Residents and whānau interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) and were provided with opportunities to discuss and clarify their rights.
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	Residents receive services free of discrimination, coercion, harassment, exploitation, abuse and neglect, supported by policies and staff education. There were no examples identified during the audit through staff, resident or whānau interviews, or in documentation reviewed. Residents reported that their property and finances were respected. There is a staff code of conduct and professional boundaries are maintained.
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	FA	Residents and/or their legal representative are provided with the information necessary to make informed decisions in line with the Code. Those interviewed — and, where appropriate, their whānau — felt empowered to actively participate in decision-making.

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, 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.		Nursing and care staff interviewed understood the principles and practice of informed consent, supported by policies in accordance with the Code. Documented consent was sighted in all files reviewed.
Subsection 1.8: I have the right to complain The people: I feel it is easy to make a complaint. When I complain I am taken seriously and receive a timely response. Te Tiriti: Māori and whānau are at the centre of the health and disability system, as active partners in improving the system and their care and support. As service providers: We have a fair, transparent, and equitable system in place to easily receive and resolve or escalate complaints in a manner that leads to quality improvement.	FA	A fair, transparent and equitable system is in place to receive and resolve complaints that leads to improvements. The process meets the requirements of the Code. Residents and whānau understood their right to make a complaint and knew how to do so. Complaint forms and a box are at reception. The Code is available in te reo Māori and English. A review of the complaints register showed actions taken, through to an agreed resolution, are documented and completed within the timeframes. Documentation sighted showed that complainants had been informed of findings following investigation. Evidence was sighted of a quality improvement following a complaint. There have been no complaints received from external sources since the previous audit. The facility manager (FM) is responsible for complaints management and follow-up. The FM and documentation evidenced that a translator/advocate who identified as Māori would be available to support people if needed.
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	PA Low	The governing body and management team assume accountability for delivering a high-quality service through supporting meaningful representation of Māori and tāngata whaikaha and honouring Te Tiriti o Waitangi through advice from an external Māori advisor. The FM confirmed knowledge of the sector, regulatory and reporting

in partnership, experiencing meaningful inclusion on all governance bodies and having substantive input into organisational operational policies. As service providers: Our governance body is accountable for delivering a highquality service that is responsive, inclusive, and sensitive to the cultural diversity of communities we serve.		requirements, and maintains currency within the field through legal advice, sector communication, training, Health New Zealand – Te Whatu Ora Waitaha Canterbury (Te Whatu Ora Waitaha Canterbury), and colleagues. The 2024-2026 business plan includes the strengths, weaknesses, opportunities and threat analysis, goals, mission statement, and future objectives. It was reviewed during March 2025. The FM brings their own skills, expertise and knowledge to the role and has completed Te Tiriti o Waitangi training. Evidence was sighted. Support is provided by the clinical nurse manager (CNM), and the RN unit co-ordinator (RNUC), and the director. When the FM is absent, the CNM carries out all the required duties under delegated authority with support from the director, RNUC and the nursing team. The director has completed Te Tiriti o Waitangi training. The management team demonstrated leadership and commitment to quality and risk management through, for example, the business plan, risk register, improving services, reporting, policy and processes, and through feedback mechanisms, and purchasing equipment. The governing body is focused on improving outcomes and achieving equity for Māori and people with disabilities. This is occurring through oversight of care planning and reviews, whānau meetings, feedback, and communication with the resident and their whānau, and health care assistants' knowledge of the resident and their likes and dislikes, including cultural and spiritual needs. Routines are flexible and can be adjusted to meet the residents' needs. The FM reported that staff identify and work to address barriers to equitable service delivery through cultural needs assessments, training, communicating with the resident, and advice from external cultural advisors. The clinical governance policy is appropriate to the size and complexity of the organisation and includes CNM and RN responsibilities to guide a holistic approach to safe clinical care. The monthly meeting schedule includes RN meetings. There was no evidence that a clinical governance structure was in place. A corrective action has been raised. Terrace View provides care for up to 64 residents at rest home or hospital level of care in a 31-bed facility, and 33 adjoining care suites/apartments

		that are under Occupational Rights Agreements. The service holds contracts with Te Whatu Ora Waitaha Canterbury for age-related residential care at rest home and hospital level including respite care, palliative care, and care for those with long-term chronic health conditions. The service has a contract with Disability Support Services, Ministry of Social Development to support younger people with a physical disability (YPD). Terrace View also provides support to non-assessed private residents. At the time of audit, 50 residents were receiving care: ten at hospital level, including one YPD resident and one receiving palliative care, and 24 residents at rest home level of care including two respite residents. In addition, there were 16 private non-assessed residents receiving packages of care.
Subsection 2.2: Quality and risk The people: I trust there are systems in place that keep me safe, are responsive, and are focused on improving my experience and outcomes of care. Te Tiriti: Service providers allocate appropriate resources to specifically address continuous quality improvement with a focus on achieving Māori health equity. As service providers: We have effective and organisation-wide governance systems in place relating to continuous quality improvement that take a risk-based approach, and these systems meet the needs of people using the services and our health care and support workers.	PA Low	The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, monitoring of outcomes, policies and procedures, and clinical incidents including infections and falls. The FM and director are in contact at least twice per week, if not in person at least once a week, then by phone. The director aims to visit the facility fortnightly in person. The FM reported the face-to-face meetings would be monthly at a minimum if the director is unable to travel to the facility. This provides the opportunity for reporting, relaying any issues and progress. Evidence was sighted of a confirmed meeting to occur the week after the audit. A selection of minutes following the monthly general meetings with all staff, and monthly management/quality assurance meetings, evidenced comprehensive reporting. These meetings have not been held consistently since the last audit. A corrective action has been raised. Residents, whānau and HCAs contribute to quality improvement through staff attendance at education/training, meetings and surveys and reporting issues of concern. Resident meeting minutes reviewed included compliments to the staff, and input into activities. The last resident survey

		was completed in July 2024, with residents satisfied with the service delivered. Quality improvement initiatives include adding solar panels, a robotic lawn mower, adding sensor lighting in the residents' bathrooms, and regular meetings with the cook, residents and diversional therapist (DT) to discuss aspects of the meals. Policies provided by an external consultant reviewed covered all necessary aspects of the service and were current. The 2025 internal audit schedule was sighted. Completed audits sighted included medication management, chemicals safety, cleaning and laundry, environment and equipment. Relevant corrective actions are developed and implemented to address any shortfalls. The service has identified quality outcomes. Apart from the evaluation of the resident survey, there was no other evidence that progress towards meeting the quality outcomes was evaluated. A corrective action has been raised. The risk register, including mitigation strategies, was sighted. The FM confirmed that the register was current. Staff document adverse and near-miss events. A sample of incident forms reviewed showed these were fully completed, incidents were investigated, action plans developed, and actions followed up in a timely manner. Evidence was sighted that resident-related incidents were being disclosed with the designated next of kin. The National Adverse Events Policy is followed, with corrective actions supporting systems learnings. The FM understood and has complied with essential notification reporting requirements. The change of clinical nurse manager notification was made on 13 March 2025 and was sighted. Evidence was sighted of the response from HealthCERT. The FM reported that there have been no police investigations, coroner's inquests, or issues-based audits since the previous audit.
Subsection 2.3: Service management The people: Skilled, caring health care and support workers	PA Low	There is a documented and implemented process for determining staffing levels and skill mixes to provide culturally and clinically safe care, 24 hours

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.		a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. Those providing care reported there were adequate staff to complete the work allocated to them. Residents interviewed supported this. At least one staff member on duty has a current first aid certificate and there is 24/7 RN coverage in the hospital. There are staff who have worked in this care home for between two weeks and 11 years. The CNM reported that, if a RN is called to the retirement village in an emergency, there is always another RN in the hospital. If there is only one RN on shift, then an HCA attends to the call. An after-hours on-call system is in place, with the RNs providing clinical cover and the FM providing support for all other areas 24/7. The FM described the recruitment process, which includes referee checks, police vetting, and validation of qualifications and annual practicing certificates (APCs) where required. The staff competency policy guides the service to ensure competencies are assessed and support equitable service delivery. Staff reported completing competency training, for example, medication, hand hygiene; however, the competency training records were not located on the day of the audit. Records of current first aid certificates were sighted, as were two syringe driver certificates and one of a RN interRAI certificate (refer 2.3.4). Continuing education is planned on an annual basis including mandatory training requirements. The CNM reported that staff hold Levels 2, 3 and 4 New Zealand Qualification Authority (NZQA) education qualifications. Staff reported undertaking training, including in competencies in cultural safety, Pacific, disability, te reo Māori, Te Titiri o Waitangi, the Code, abuse and neglect, IP&C, de-escalation and safe practice, fire training fire evacuations, first aid, medication, wounds, care plans, incident reporting, hand hygiene, and pressure cares. Documentation in a sample of staff files evidenced training in continence, restraint, dementia, wounds, hand hygiene, chemicals, interRAI, syringe driver, and first aid. A corrective action has been raised. The RNUC reported that five of the seven registered nurses are interRAI trained.

Subsection 2.4: Health care and support workers The people: People providing my support have knowledge, skills, values, and attitudes that align with my needs. A diverse mix of people in adequate numbers meet my needs. Te Tiriti: Service providers actively recruit and retain a Māori health workforce and invest in building and maintaining their capacity and capability to deliver health care that meets the needs of Māori. As service providers: We have sufficient health care and support workers who are skilled and qualified to provide clinically and culturally safe, respectful, quality care and services.	FA	Human resources management policies and processes are based on good employment practice and relevant legislation. Current annual practising certificates were sighted for the seven registered nurses, three pharmacists, a dietitian, and 10 general practitioners. The diversional therapist's certificate of qualification was sighted. The service has a role-specific staff orientation that includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. New staff described their orientation, including that they worked across shifts for up to one week and signed off a checklist as tasks were completed. Documentation evidenced the orientation for the sample required. Staff confirmed that performance is reviewed and discussed during and after orientation, and annually thereafter. Staff have either completed the review or are booked. Completed reviews were sighted.
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.	PA Low	The multidisciplinary team works in partnership with the resident and their whānau to support wellbeing. Five residents' files were reviewed: three residents receiving rest home care and two receiving hospital level care including a resident receiving services under the persons with a physical disability (YPD) contract. The files reviewed verified that a care plan is developed by a registered nurse following assessment, including consideration of the person's lived experience, and which considers wider service integration, where required. Early warning signs and risks, with a focus on prevention or escalation for appropriate interventions, were recorded. Timeframes for the initial assessment, medical or nurse practitioner assessment, initial care plan, long-term care plan and review timeframes meet contractual and policy requirements. The sample of files reviewed was extended to review the timing of the interRAI assessment and care planning for six recent admissions; this confirmed that not all interRAI assessments had been completed within the contractually required timeframes and the corrective action raised at the last audit remains open;

		refer criterion 3.2.1. Residents' cultural and spiritual needs are assessed by the diversional therapist and physical needs are assessed by registered nurses. Both are documented in the care plan. However, in care plans reviewed, cultural needs, values and beliefs were not always identified and documented, and the personal goals and aspirations of residents were not clear; refer criterion 3.2.3. Management of any specific medical conditions was well documented, with evidence of systematic monitoring and regular evaluation of responses to planned care, including the use of a range of outcome measures. Short-term care plans were developed, if necessary, and examples were sighted for infections and wound care. These are reviewed weekly or earlier if clinically indicated. General or nurse practitioner review occurs at a minimum of three-monthly, with resident and whānau input, when possible. Six-monthly interRAI assessments were verified to have been completed as required and care plan review had occurred. Where progress was different to that expected, changes were made to the care plan in collaboration with the resident and whānau. Residents and whānau confirmed active involvement in the process. A general practitioner was interviewed who stated the care was of a high standard and they had no concerns. A contracted physiotherapist interviewed confirmed their instructions were followed and resident and whānau interviews confirmed high satisfaction with care, including satisfaction with communication from staff.
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	PA Moderate	The medication management policy is current and in line with the Medicines Care Guide for Residential Aged Care. A safe system for medicine management using an electronic system was observed on the day of audit, including the recording of allergies and sensitivities. Staff who administer medicines were observed to be competent. However, documented medication competencies were not sighted; refer criterion 2.3.4. Registered nurses complete a syringe driver competency to support palliative residents; these were sighted, and current, for three nurses.

practice guidelines.		Medications are supplied to the facility from a contracted pharmacy. Medicines are stored safely, including those requiring refrigeration, and all medicines were stored within the recommended temperature range. However, not all medicines were within current use-by dates and not all medication was correctly labelled (refer 3.4.1). Controlled drugs are held securely and entered into a controlled drug register. Review of the register confirmed documentation met regulations and the required stock checks occur. Adverse events are documented in the resident's file and an incident report completed. File review showed medication errors were investigated and managed appropriately, including notification to the general practitioner and whānau. The required three-monthly general or nurse practitioner review was consistently recorded on the medicine chart. Standing orders are not used. Self-administration of inhalers is facilitated and managed safely. This was confirmed by interview and review of documentation.
Subsection 3.5: Nutrition to support wellbeing The people: Service providers meet my nutritional needs and consider my food preferences. Te Tiriti: Menu development respects and supports cultural beliefs, values, and protocols around food and access to traditional foods. As service providers: We ensure people's nutrition and hydration needs are met to promote and maintain their health and wellbeing.	FA	The food service is provided by a contracted service. All food is prepared onsite. The menu has been developed in line with recognised nutritional guidelines for people using the services, taking into consideration the food preferences, dietary needs, intolerances, allergies, and cultural preferences of the residents. Evidence of resident satisfaction with meals was verified from resident and whānau interviews. Concerns raised through the resident meetings were being addressed. The service operates with an approved food safety plan and registration.
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.	FA	Transfer or discharge from the service is planned and managed safely, with coordination between services and in collaboration with the resident and whānau. Risks and current support needs are identified and managed. This was verified in the review of a recent transfer. Files evidenced

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.		whānau being kept well informed during the transfer of their relative.
Subsection 4.1: The facility The people: I feel the environment is designed in a way that is safe and is sensitive to my needs. I am able to enter, exit, and move around the environment freely and safely. Te Tiriti: The environment and setting are designed to be Māori-centred and culturally safe for Māori and whānau. As service providers: Our physical environment is safe, well maintained, tidy, and comfortable and accessible, and the people we deliver services to can move independently and freely throughout. The physical environment optimises people's sense of belonging, independence, interaction, and function.	FA	The building warrant of fitness expires on 12 February 2026. Equipment tagging and testing was current, as confirmed in records, interviews with the FM, and observation. Current calibrations of biomedical records were sighted. The maintenance schedule was sighted. Residents and staff confirmed they know the processes they should follow if any repairs or maintenance are required. Spaces were culturally inclusive and suited the needs of the resident groups. Evidence was sighted of personal cultural and spiritual items. Residents and staff were happy with the environment, including heating and ventilation, natural light, privacy, and maintenance.
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.	PA Low	The infection prevention and control coordinator (IPCC), who is a registered nurse, is responsible for overseeing and implementing the IP programme. The programme has been developed by those with IP expertise and is linked to the quality improvement programme. However, evidence was not available to confirm the programme had been approved by the governance body or reviewed in the last 18 months; refer criterion 5.2.2. This was confirmed by the IPCC and review of the programme documentation. Staff were familiar with policies and practices and described education occurring as part of orientation and ongoing education. They were observed to follow infection prevention processes correctly. However, it was not possible to confirm all staff had completed the required education;

		refer criterion 2.3.4. Residents and their whānau are educated about infection prevention in a manner that meets their needs.
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.	PA Low	Surveillance of health care-associated infections (HAIs) is appropriate to that recommended for the type of services offered, and is in line with risks and priorities defined in the infection control programme. Standardised definitions are used and policy described how to include ethnicity data. However, this has not yet occurred, and the corrective action raised at the last audit remains open; refer criterion 5.4.3. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors, and required actions. The IPCC described sharing results of surveillance with staff at staff meetings when they occur; refer criterion 2.2.2. No evidence was available to show that results of surveillance and recommendations to improve performance, where necessary, have been identified and reported to the governing body. Refer criterion 5.4.4.
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	Maintaining a restraint-free environment is the aim of the service. The governance and management group demonstrated commitment to this through the policy and the business plan and this was confirmed by staff. At the time of audit, no residents were using a restraint. The CNM reported that a restraint would be used as a last resort when all alternatives have been explored. Orientation and planned ongoing education included restraint and management of challenging behaviours. Staff confirmed they have received training. Training records were not available on the day of the audit and the provider was unable to evidence the required training had been completed (refer 2.3.4).

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 2.1.11 There shall be a clinical governance structure in place that is appropriate to the size and complexity of the service provision.	PA Low	The clinical governance policy is appropriate to the size and complexity of the organisation and includes CNM and RN responsibilities to guide a holistic approach to safe clinical care. The monthly meeting schedule includes RN meetings. The CNM has been in the role for two weeks. The previous CNM resigned three months prior. The RNUC undertook the CNM role during the three months. The FM was unable to locate any clinical governance/RN meetings minutes since the last audit. There was no evidence that a clinical governance structure was in place.	The provider was unable to evidence there was a clinical governance structure in place.	Reinstate the clinical governance structure and ensure the RN meetings are held as required. 90 days
Criterion 2.2.2	PA Low	The annual meeting schedule	There was no evidence that	The monthly meetings are

Service providers shall develop and implement a quality management framework using a risk-based approach to improve service delivery and care.		identified that monthly meetings include general staff and HCA, management and quality assurance meetings would occur. Meeting minutes evidenced that the information discussed at the general staff and HCA meeting was comprehensive. It included areas for reporting adverse events, medication errors, infection prevention and control (IP&C) wounds, complaints and compliments, training, equipment, staffing, restraint, and audits. Since January 2024, five meetings had been held, the last being on 26 September 2024. Meeting minutes evidenced that the information discussed at the management and quality assurance meetings included occupancy, adverse events, IP&C, wounds, staffing, food, training, quality improvements, equipment and general business. Since February 2024, six meetings had been held. There was no evidence that the scheduled monthly general staff and HCA meetings and the management and quality assurance meetings have been held consistently since the last audit. There was no evidence of collation of data or of data analysis, or that progress is evaluated against outcomes. A corrective action has been raised.	the scheduled quality and risk meetings have been held monthly since the last audit. There was no evidence of collation or analysis of data or that progress is evaluated against outcomes.	reinstated and occur as scheduled. Data is collated and analysed, and progress is evaluated against outcomes. 90 days

Criterion 2.2.3 Service providers shall evaluate progress against quality outcomes.	PA Low	The review of the quality framework provided evidence that quality outcomes had been identified for the facility to work on. Apart from the evaluation of the resident survey, there was no other evidence that progress towards the quality outcomes was evaluated.	The facility is not consistently evaluating progress towards meeting the quality outcomes as required by the standard.	Ensure progress towards meeting the quality outcomes is evaluated as required by the standard. 90 days
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	Staff reported undertaking training, including competencies related to cultural safety, Pacific peoples, disability, te reo Māori, Te Tiriti o Waitangi, the Code, abuse and neglect, IPC, de-escalation techniques and safe practice, fire training including fire evacuations, first aid, medication management, wounds, care plans, incident reporting, hand hygiene, and pressure cares. Documentation in a sample of staff files evidenced training in continence, restraint, dementia, wounds, hand hygiene, chemicals, interRAI, syringe driver, and first aid. The FM and RNUC reported that, due to a change of CNM and being unfamiliar with the recording system, the provider was unable to provide training records, including competency records, on the day of the audit.	Training records, including competency records, were not available on the day of the audit and the provider was unable to evidence the required training had been completed.	Ensure training records, including competency records, are located, and that they continue to record completed training as required. 90 days
Criterion 3.2.1 Service providers shall	PA Low	Registered nurses are responsible for assessments, including the interRAI assessment and care planning.	Four out of six interRAI assessments for recent admissions were not	Ensure all residents have an interRAI assessment completed withing 21 days of admission as

engage with people receiving services to assess and develop their individual care or support plan in a timely manner. Whānau shall be involved when the person receiving services requests this.		Progress has been made to address the shortfalls identified at the last audit. Initial care plans were seen to be completed on admission, medical assessment had occurred, and a long-term care plan developed. However, in four out of six admissions since October 2024, the interRAI assessment was not completed within the contractually required timeframe, and as a result, the long-term care plan was not based on the interRAI assessment as required. Due to the progress made and the continued commitment to improve, this finding is rated low risk.	completed within the contractually required timeframe following admission.	contractually required. 180 days
Criterion 3.2.3 Fundamental to the development of a care or support plan shall be that: (a) Informed choice is an underpinning principle; (b) A suitably qualified, skilled, and experienced health care or support worker undertakes the development of the care or support plan; (c) Comprehensive assessment includes consideration of people's lived experience; (d) Cultural needs, values, and beliefs are considered; (e) Cultural assessments are completed by culturally competent workers and are	PA Low	Assessments of physical needs are carried out by registered nurses on admission, while the diversional therapist (DT) is responsible for assessing cultural and spiritual needs. Assessment is occurring. However, the cultural needs, values and beliefs were not always identified and the goals and aspirations related to cultural and spiritual needs were not documented. Supports to achieve residents' goals related to cultural and spiritual needs were not identified. Physical needs were well documented; however, goals in the care plan were generic in nature and the residents' individual personal strengths, goals and aspirations were not documented. This was verified in five of five files reviewed. The clinical	Resident's individual and personal strengths, goals and aspirations related to cultural and spiritual needs were not documented in care plans reviewed.	Ensure the personal strengths, goals and aspirations related to cultural and spiritual needs of residents are documented and supports to achieve these personal goals are identified. 180 days

accessible in all settings and circumstances. This includes traditional healing practitioners as well as rākau rongoā, mirimiri, and karakia; (f) Strengths, goals, and aspirations are described and align with people's values and beliefs. The support required to achieve these is clearly documented and communicated; (g) Early warning signs and risks that may adversely affect a person's wellbeing are recorded, with a focus on prevention or escalation for appropriate intervention; (h) People's care or support plan identifies wider service integration as required.		nurse manager and unit coordinator discussed a quality improvement initiative that is planned to personalise care planning; however, this has not yet begun.		
Criterion 3.4.1 A medication management system shall be implemented appropriate to the scope of the service.	PA Moderate	A safe system for medicine management using an electronic system was observed on the day of audit. Medications are supplied to the facility from a contracted pharmacy and resupply can be ordered via the electronic system. Medicines are stored safely and there are processes in place for the safe disposal of medications no longer required. However, not all aspects of medication storage and management met the required standards. Not all medication was appropriately labelled, and expired medication and medication for	Not all aspects of the medication management system met the required standard. These included: • Expired medications had not been returned to the pharmacy. • Medications were without a pharmacy label to identify the resident's name, prescription details and administration instructions. • Medications where the	Ensure that all aspects of the medication management system meet the required standard, including the labelling of medications, the return of expired medication to the pharmacy, and that individually dispensed medication is not used as communal ward stock. 30 days

		a discharged resident had not been returned to the pharmacy. Individually dispensed medication was being used as communal ward stock.	pharmacy label was worn and illegible, and as a result the prescriber's name and administration instructions were not identifiable. • Eye drops and eye ointments had not been discarded after the required time frame from opening. • Not all eye drops were labelled with a date of opening. • Medication for a discharged resident remained in the medication trolley and had not been returned to the pharmacy. • Individually dispensed medications were being used as ward stock and administered to multiple residents.	
Criterion 5.2.2 Service providers shall have a clearly defined and documented IP programme that shall be: (a) Developed by those with IP expertise; (b) Approved by the governance body; (c) Linked to the quality improvement programme; and	PA Low	There is an infection prevention programme in place that is linked to the quality improvement programme. However, evidence was not available to confirm the programme had been approved by governance and the programme had not been reviewed or reported on in the last 18 months.	The infection prevention programme had not been approved by governance and had not been reviewed and reported on annually.	Ensure the infection prevention programme is approved by governance and is reviewed and reported on annually. 180 days

(d) Reviewed and reported on annually.				
Criterion 5.4.3 Surveillance methods, tools, documentation, analysis, and assignment of responsibilities shall be described and documented using standardised surveillance definitions. Surveillance includes ethnicity data.	PA Low	Policy describes the surveillance methods and tools, including standardised definitions and how to include ethnicity data. Monthly collation of data had occurred, and the number of infections had been graphed. However, ethnicity data had not been included.	Infection surveillance data did not include ethnicity data.	Ensure ethnicity data is included in infection surveillance, as required by the standard and as described in policy. 180 days
Criterion 5.4.4 Results of surveillance and recommendations to improve performance where necessary shall be identified, documented, and reported back to the governance body and shared with relevant people in a timely manner.	PA Low	Results of surveillance are reported to staff at staff meetings when these occur. However, there was no evidence that surveillance data had been reported to governance and no evidence that recommendations to improve performance had been identified and reported to governance.	Infection surveillance data had not been reported to governance and recommendations to improve performance had not been identified where necessary and reported to governance.	Ensure the results of infection surveillance and recommendations to improve performance are identified where necessary and reported to governance. 180 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.