Glenwood South Canterbury Trust - Glenwood Home

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Anglican-Methodist South Canterbury Glenwood Home Trust Board
Premises audited:	Glenwood Home
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 12 May 2025 End date: 13 May 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: 33

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

Glenwood Home is certified to provide hospital (geriatric and medical),and rest home services for up to 45 residents. There were 33 residents on the days of audit.

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

There have been several changes in governance and management since the last audit.

The interim general manager is supported by an interim clinical manager, registered nurses and a team of experienced healthcare assistants. There are quality systems and processes being implemented. Feedback from residents and family/whānau was positive about the care and the services provided. An induction and in-service training programme are in place to provide staff with appropriate knowledge and skills to deliver care.

There were no shortfalls identified at the previous audit.

This surveillance audit has identified shortfalls related to business planning, quality reporting, implementation of the quality system; staff competencies and training, annual appraisals; care-planning timeframes; care plan interventions; monitoring; care plan evaluations; medication management; annual review of the infection control programme; and outbreak documentation.

Ō tātou motika | Our rights

Includes 10 subsections that support an outcome where people receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of people's rights, facilitates informed choice, minimises harm, and upholds cultural and individual values and beliefs.		Subsections applicable to this service fully attained.

There is a Māori health plan in place for the organisation. Te Tiriti O Waitangi is embedded and enacted across policies, procedures, and delivery of care. The service recognises Māori mana motuhake and this is reflected in the Māori health plan. A Pacific health plan is in place which ensures cultural safety for Pacific peoples, embracing their worldviews, cultural, and spiritual beliefs. Glenwood Home demonstrates their knowledge and understanding of resident's rights and ensures that residents are well informed in respect of these. There are established systems to facilitate informed consent and to protect resident's property and finances. The complaints process is responsive, fair and equitable. It is managed in accordance with the Code of Health and Disability Services Consumers' Rights and complainants are kept fully informed.

Hunga mahi me te hanganga | Workforce and structure

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

Glenwood Home is re- establishing a governance structure with a new chairman and board members. The new governance structure includes clinical governance that is appropriate to the size and complexity of the service provided. The interim general

manager is experienced in health care management and the interim clinical manager has experience and expertise in clinical and aged care management. Barriers to health equity are identified, addressed and services delivered that improve outcomes for Māori. The service has recently introduced a new quality and risk management system that takes a risk-based approach. There is a process for following the National Adverse Event Reporting policy and interim management have an understanding and comply with statutory and regulatory obligations in relation to essential notification reporting. There is a staffing and rostering policy. An orientation programme and 2025 staff training plan are in place to support staff in delivering safe quality care.

Ngā huarahi ki te oranga | Pathways to wellbeing

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

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

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

All residents’ transfers and referrals occurs in a coordinated manner.

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.

A current building warrant of fitness in in place. Electrical equipment has been tested and tagged. All medical equipment has been serviced and calibrated.

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

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

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

Surveillance data is undertaken, including the use of standardised surveillance definitions, and ethnicity data.

Here taratahi | Restraint and seclusion

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

The restraint coordinator is the interim clinical manager. The facility has no residents using restraint. The service considers least restrictive practices, implementing de-escalation techniques and alternative interventions, and only uses an approved restraint as the last resort.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Subsection	0	10	0	2	6	0	0
Criteria	0	36	0	4	9	0	0

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

Attainment against the Ngā paerewa Health and disability services standard

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

For more information on the standard, please click here.

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

Subsection with desired outcome	Attainment Rating	Audit Evidence
Subsection 1.1: Pae ora healthy futures Te Tiriti: Māori flourish and thrive in an environment that enables good health and wellbeing. As service providers: We work collaboratively to embrace, support, and encourage a Māori worldview of health and provide high-quality, equitable, and effective services for Māori framed by Te Tiriti o Waitangi.	FA	A Māori health plan is documented for the service, which Glenwood Home utilises as part of their strategy to embed and enact Te Tiriti o Waitangi in all aspects of service delivery. At the time of the audit the service had both residents and staff who identified as Māori. The service recognises Māori mana motuhake and this is reflected in the Māori health plan and in the care plan of residents identified as Māori.
Subsection 1.2: Ola manuia of Pacific peoples in Aotearoa The people: Pacific peoples in Aotearoa are entitled to live and enjoy good health and wellbeing. Te Tiriti: Pacific peoples acknowledge the mana whenua of Aotearoa as tuakana and commit to supporting them to achieve tino rangatiratanga. As service providers: We provide comprehensive and equitable health and disability services underpinned by Pacific worldviews and developed in collaboration with Pacific peoples for improved health outcomes.	FA	The Ola Manuia Pacific Health and Action Plan and Te Mana Ola are the chosen models for the Pacific health plan and Pacific Peoples Culture and General Ethnicity Awareness Policy. At the time of the audit there were no residents who identified as Pasifika. There were Pacific staff who could confirm that cultural safety for Pacific peoples, their worldviews, cultural, and spiritual beliefs are embraced at Glenwood Home.

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	The Code of Health and Disability Services Consumers' Rights (the Code) is displayed in English and te reo Māori. The interim clinical manager interviewed, demonstrated how it is also provided in welcome packs in the language most appropriate for the resident, to ensure they are fully informed of their rights. Interviews with two family/whānau (one hospital and one rest home), and six residents (three rest home and three hospital level) confirmed they are informed of their rights and their choices are respected.
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	The Glenwood Home organisational policies provide guidelines to prevent any form of institutional racism, discrimination, coercion, harassment, or any other exploitation. There are established policies, and protocols to respect resident's property, including an established process to manage and protect resident finances. All staff at Glenwood Home are trained in and aware of professional boundaries, as evidenced in orientation documents; however, staff have not received training in abuse and neglect for over two years (link 2.3.4) Seven staff were interviewed; three healthcare assistants (HCAs), two registered nurses (RN), one maintenance man and one kitchen manager and two management staff (interim general manager and interim clinical manager) demonstrated an understanding of professional boundaries when interviewed.
Subsection 1.7: I am informed and able to make choices The people: I know I will be asked for my views. My choices will be respected when making decisions about my wellbeing. If my choices cannot be upheld, I will be provided with information that supports me to understand why. Te Tiriti: High-quality services are provided that are easy to access and navigate. Providers give clear and relevant messages so that individuals and whānau can effectively manage their own health, keep well, and live well. As service providers: We provide people using our services or their legal representatives with the information necessary to	FA	There are policies around informed consent that meet the requirements of the Code. Resident files reviewed included completed general consent forms and consents for influenza and Covid-19 vaccinations. Residents and family/whānau interviewed could describe what informed consent was and knew they had the right to choose. Consent forms were appropriately signed by the activated enduring power of attorney (EPOA) or welfare guardians. All documentation regarding EPOA and activation is on file.

make informed decisions in accordance with their rights and their ability to exercise independence, choice, and control.		
Subsection 1.8: I have the right to complain The people: I feel it is easy to make a complaint. When I complain I am taken seriously and receive a timely response. Te Tiriti: Māori and whānau are at the centre of the health and disability system, as active partners in improving the system and their care and support. As service providers: We have a fair, transparent, and equitable system in place to easily receive and resolve or escalate complaints in a manner that leads to quality improvement.	FA	The complaints procedure is provided to residents and family/whānau during the resident's entry to the service. Access to complaints forms is located at the entrance to the facility or on request from staff. The Code and complaints process is visible, and available in te reo Māori, and English. A complaints register is being maintained which includes all complaints, dates and actions taken. There have been five complaints made in 2024. One of the complaints include the involvement and support of the National Health and Disability Advocacy service. All complaints were resolved to the satisfaction of the complainant. No complaints were received in 2025 year to date. There were no trends identified. Complaints documentation reviewed included follow up and outcome letters demonstrated that complaints are being managed in accordance with guidelines set by the Health and Disability Commissioner (HDC). The interim general manager is responsible for the management of complaints. Residents or family/whānau making a complaint can involve an independent support person in the process if they choose. The complaints process is linked to advocacy services. Discussions with residents and family/whānau confirmed that they were provided with information on the complaints process and remarked that any concerns or issues they had, were addressed promptly. Information about the support resources for Māori is available to staff to assist Māori in the complaints process. Interpreters contact details are available. The interim general manager acknowledged their understanding that for Māori, there is a preference for face-to-face communication and to include family/whānau participation.
Subsection 2.1: Governance The people: I trust the people governing the service to have the knowledge, integrity, and ability to empower the communities they serve. Te Tiriti: Honouring Te Tiriti, Māori participate in governance in	PA Moderate	The Glenwood South Canterbury Trust Board owns and operates Glenwood Home. The board has undergone significant changes recently with several board members leaving and the appointment of five new persons with expertise to board roles. During this transition, the focus has been on employing new staff into management roles.

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.		Glenwood Home is certified to provide rest home and hospital (geriatric and medical) levels of care for up to 45 residents. At the time of the audit there were 33 residents. This included nine residents at rest home level care and 24 residents at hospital level care. There were four residents on mental health contracts. There were no residents on respite care. All other residents were under the age-related residential care (ARRC) contract. There are 13 dedicated rest home beds, and 32 beds certified as dual purpose. There were no double or shared rooms. The chair of the board interviewed confirmed the governance structure. The Governance Board consists of six board members and the chairperson, each with their own expertise. Five members of the board are recent appointments following the resignations of seven previous board members. The boards te ao Māori strategy incorporates the principles of Te Tiriti o Waitangi principles, including partnership in recognising all cultures as partners and valuing each culture for their contributions. An independent cultural advisor is one of the new board members and is providing advice on actions to address barriers and provide equitable care for Māori accessing care and employment at Glenwood home. The chair of the board explained how barriers to health equity are identified, addressed and services delivered that improve outcomes for Māori. The Board meets monthly and follows a comprehensive agenda including reviewing operational and clinical reports. There is a 2021-2024 business plan could not be located. The business plan goals for 2025 have not yet been documented. The general manager position first changed in mid-2023 and again in December 2024. There have been changes in clinical management from March 2024 and again in February 2025. At various times throughout this transition there were vacancies in both roles. Health NZ were notified of board and management changes. The interim general manager is supported by an interim clinical manager at Glenwood Home. The interim general manager has managed nursing staff; however, is new to age care. The interim clinical manager (CM) is a registered nurse and has extensive managerial experience in several residential care homes over the previous twenty years and is fulfilling an interim role pending the commencement of a new CM in late May 2025. Both managers are jointly responsible for the day to day operations of the facility. They are supported by RNs and an experienced care team. The

		interim general manager and interim clinical manager meet monthly with the board to facilitate the link between management and governance and more often if required. Recent reports to the board include updates on the quality and risk management programme, including meetings; training; health and safety; infection prevention and control; adverse events; internal audits; complaints (if any); and health and safety. There was no evidence to support reports on quality and risk management were submitted to the board for 2024. The interim general manager and the interim clinical manager are knowledgeable around contractual and legislative requirements. There is clinical representation on the Board who provides clinical governance. The interim general manager undertakes professional development activities related to managing staff and has attended a number of online webinars. The interim clinical manager is responsible for clinical governance and has maintained at least eight hours annually of professional development activities related to managing an aged care facility, through attending regular aged residential care forums and completion of online training.
Subsection 2.2: Quality and risk The people: I trust there are systems in place that keep me safe, are responsive, and are focused on improving my experience and outcomes of care. Te Tiriti: Service providers allocate appropriate resources to specifically address continuous quality improvement with a focus on achieving Māori health equity. As service providers: We have effective and organisation-wide governance systems in place relating to continuous quality improvement that take a risk-based approach, and these systems meet the needs of people using the services and our health care and support workers.	PA Moderate	A quality and risk management programme is documented. The quality and risk management systems include performance monitoring through internal audits and through the collection of clinical indicator data. Recent quarterly quality management and health and safety meetings, monthly clinical and general staff meetings provide an avenue for discussions in relation to (but not limited to) quality data; health and safety; infection control/pandemic strategies; complaints; staffing; and education. Internal audits and collation of data were documented as taking place in 2025; however, these were not consistently completed in 2024. Completed internal audits identify corrective actions are documented where indicated to address service improvements. Corrective actions provide evidence of progress and sign off when achieved. A meeting schedule for 2025 has been documented; however, meetings are not evidenced as being held according to the schedule due to shortage of key staffing positions. There is no evidence of staff, clinical or quality meetings in 2024. Quality and management meeting minutes in 2025 identify discussion of quality data, trends, internal audit results, complaints, restraint, education,

		human resources and health and safety. Corrective actions are discussed at quality management meetings to ensure any outstanding matters are addressed with sign off when completed. Quality objectives have not been documented for 2024 or 2025. The service recently (beginning of April 2025) moved to an electronic resident and quality management system which includes an ability to benchmark both internally and externally. Resident and family/whānau satisfaction surveys were not completed in 2024 or 2025 to date. A health and safety system is in place. Hazard identification forms are completed electronically, and an up-to-date hazard and risk register was reviewed (sighted). Staff are kept informed on health and safety issues in handovers and meetings. Electronic entries are completed for each incident/accident, and immediate action is documented with any follow-up action(s) required. This was evidenced in a sample of ten accident/incident records reviewed. Incident and accident data is collated monthly and analysed. Results are discussed in the quality management, clinical and general staff meetings and at handover. Each event involving a resident reflected a clinical assessment and a timely follow up by an RN. Discussions with the interim general manager evidenced awareness of their requirement to notify relevant authorities in relation to essential notifications. There was one Section 31 notification in February 2025 related to a fire with smoke damage and distribution of toxic dust into the kitchen, staff room, corridors and ten resident rooms. Environmental scientists were involved in identifying the requirement for industrial cleaning. Additional notifications were lodged for changes in management and board members and a behavioural incident. A severity assessment code (sac) report for a self-harm incident was reported to the Health Safety and Quality Commission. There have been no other events in 2024 that required notification.
Subsection 2.3: Service management The people: Skilled, caring health care and support workers listen to me, provide personalised care, and treat me as a whole person.	PA Moderate	The roster provides sufficient and appropriate coverage for the effective delivery of care and support. The interim general manager and the interim clinical manager are available full time from Monday to Friday and also provide after-hours on-call cover. The RNs, activities staff and maintenance person hold current first aid certificates. There is a first aid

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.		trained staff member on duty 24/7. Staff and residents are informed when there are changes to staffing levels, evidenced in staff interviews and recent meeting minutes. The roster reviewed evidenced that short notice absences are covered by casual staff. There is an RN on all shifts with a stable RN workforce since January 2025. There are sufficient numbers of HCAs allocated on each shift to meet the care needs of residents. There are separate kitchen staff, maintenance, laundry and housekeeping staff. The annual education and training schedule has not been evidenced as documented for 2024 and there is no evidence that staff were provided with opportunities to attend training or complete annual competencies. The current management team identified this was an area for improvement and documented a corrective action plan. A plan for 2025 has been documented with an emphasis on compulsory training topics. There is evidence of increased training since January 2025. All staff are required to complete mandatory training and there is evidence staff are actively working on this; however, not all required training has been completed at the time of the audit. Staff reported they are provided with training on an online platform, formal face to face and impromptu toolbox training. Cultural awareness and cultural safety training provided this year. All staff are required to complete competency assessments as part of their orientation and include hand hygiene, correct use of personal protective equipment (PPE) and manual handling and transfer; however, this was still in progress for some staff. Staff who administer medication complete annual medicine competency and a record of completion is maintained. A mental health trainer comes to the facility two to four weekly to provide education to RN's. The interim general manager is actively encouraging HCAs to attain Careerforce New Zealand Qualification Authority (NZQA) levels in Health and Wellbeing. Thirty two of 39 HCAs have attained a level 3 NZQA qualification or higher. On interview HCAs were positive regarding education opportunities made available to them by the interim management team. All RNs are encouraged to attend any external training sessions on offer. A record of completion is maintained on an electronic register. Additional RN specific competencies include syringe driver and interRAI assessment competency. There are 10 RNs in total including the interim

		general and clinical managers with five being 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.	PA Low	Five staff files (two RN's and three healthcare assistants) reviewed included evidence of completed orientation, training and competencies and professional qualifications on file where required. There are job descriptions in place for all positions that includes outcomes, accountability, responsibilities, authority, and functions to be achieved in each position. A register of practising certificates is maintained for all health professionals. The service has a role-specific orientation programme in place that provides new staff with relevant information for safe work practice and includes buddying when first employed. Competencies are completed at orientation. The service demonstrates that the orientation programme supports RNs and HCAs to provide a culturally safe environment for Māori. Not all staff who have been employed for a year or more have a current performance appraisal on file.
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 Moderate	Five resident files were reviewed: three hospital and two rest home (including one under a mental health contract) resident file. The registered nurses (RN) are responsible for all residents' assessments, care planning and evaluation of care. Care plans are based on data collected during the initial nursing assessments, which include dietary needs, pressure injury, falls risk, social history, and information from pre-entry assessments. Initial assessments and long-term care plans were completed for residents, detailing needs, and preferences. Initial care plans are completed within 24 hours of admission. The individualised long-term care plans are developed with information gathered during the initial assessments and the interRAI assessment. All long-term care plans and interRAI assessments (including the residents on mental health contracts) sampled had been completed within three weeks of the residents' admission to the facility. Documented interventions and early warning signs did not always meet the residents assessed needs. Goals were not always included as part of the care planning process. The

		service has recently transitioned to a new electronic resident management system. The activity assessments include a cultural assessment which gathers information about cultural needs, values, and beliefs. Information from these assessments is used to develop the resident's individual activity care plan. Short-term care plans are developed for acute problems, for example infections, wounds, and weight loss. Resident care is evaluated on each shift and reported at handover and in the progress notes. If any change is noted, it is reported to the RN. Long-term care plans are formally evaluated every six months; however, not always in conjunction with the interRAI re-assessments or when there is a change in the resident's condition. InterRAI reassessments and care plan evaluations were not consistently completed within required timeframes. Evaluations are documented by an RN, however, do not consistently include the degree of achievement towards meeting desired goals and outcomes. Residents interviewed confirmed assessments are completed according to their needs and in the privacy of their bedrooms. There was evidence of family/whānau involvement in care planning and documented ongoing communication of health status updates. Family/whānau interviews and resident records evidenced that family/whānau are informed where there is a change in health status. The service has policies and procedures in place to support all residents to access services and information. The service supports and advocates for residents with disabilities to access relevant disability services. The initial medical assessment is undertaken by the general practitioner (GP) within the required timeframe following admission. Residents have ongoing reviews by the GP within required timeframes and when their health status changes. The GP visits weekly and as required. Medical documentation and records reviewed were current. The GP interviewed stated that there the new interim management team had made positive changes recently and that the new RNs were enthusiastic. The contracted GP is also available after hours for the facility. A physiotherapist visits the facility twice a week and on request, to review residents referred by the registered nurses. There is access to a continence specialist as required. A podiatrist visits regularly and a dietitian, speech language therapist, hospice and medical specialists are available as required through Health New Zealand.

		An adequate supply of wound care products were available at the facility. A review of the wound care plans evidenced that wounds were assessed in a timely manner and reviewed at appropriate intervals; however, assessments do not consistently reflect an accurate classification of the wound. Photos were taken when this was required. Where wounds required additional specialist input, staff explained this was initiated, and a wound nurse specialist was consulted. At the time of the audit there were eleven residents with 21 active wounds, including two facility acquired stage 2 pressure injuries. The progress notes are recorded and maintained in the integrated records. Monthly observations such as weight and blood pressure were completed and are up to date. Neurological observations are recorded following un-witnessed falls; however, these were not consistently completed as per policy. A range of monitoring charts are available for the care staff to utilise. These include (but not limited to) monthly blood pressure; weight monitoring; bowel records; repositioning chart; blood glucose levels; intentional rounding, food intake charts, fluid balance monitoring, behaviour distress monitoring. Staff interviews confirmed they are familiar with the needs of all residents in the facility and that they have access to the supplies and products they require to meet those needs. Staff receive handover at the beginning of their shift, as observed on the day of audit.
Subsection 3.4: My medication The people: I receive my medication and blood products in a safe and timely manner. Te Tiriti: Service providers shall support and advocate for Māori to access appropriate medication and blood products. As service providers: We ensure people receive their medication and blood products in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Moderate	There are policies available for safe medicine management that meet legislative requirements. Staff who administer medications on the days of the audit have been assessed for competency on an annual basis. Education around safe medication administration has been provided as part of the competency process. Registered nurses are required to complete syringe driver training. Staff were observed to be safely administering medications. The registered nurses and medication competent HCAs interviewed could describe their role regarding medication administration. The service currently uses blister packs for regular medication, controlled drugs, short course, and for pro re nata (PRN) medications. All medications are checked on delivery against the medication chart and any discrepancies

		are fed back to the supplying pharmacy. Medications were appropriately stored in the facility medication rooms. The medication fridge and medication room temperatures are monitored daily, and all were within accepted ranges. All stored medications are checked monthly. Eyedrops have been dated on opening and all within the expiry date. Regular physical checks and reconciliation of controlled drugs has been completed. The controlled drug register is checked monthly; however, not all entries evidenced two signatures and six monthly stocktakes were not consistently completed. Ten electronic medication charts were reviewed. The medication charts reviewed identified that the GP had reviewed all resident medication charts three-monthly, and each drug chart has photo identification and allergy status identified. Indications for use were noted for PRN medications, and effectiveness of PRN medications was consistently documented in the electronic medication management system and progress notes. There were no residents self-administering medications; however, there are policies and procedures to guide self-administration should a resident request and wishes to do so. No vaccines are kept on site and no standing orders are used. There was documented evidence in the clinical files that residents and relatives are updated around medication changes, including the reason for changing medications and side effects. When medication related incidents occurred, these were investigated and followed up on.
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	Food preferences and cultural preferences are encompassed into the menu. The kitchen receives resident dietary forms and is notified of any dietary changes for residents. Dislikes and special dietary requirements are accommodated, including food allergies. The cook reported they accommodate residents' requests. There is a verified food control plan which is current until August 2025. The residents and family/whānau interviewed were complimentary regarding the standard of food provided.

Subsection 3.6: Transition, transfer, and discharge The people: I work together with my service provider so they know what matters to me, and we can decide what best supports my wellbeing when I leave the service. Te Tiriti: Service providers advocate for Māori to ensure they and whānau receive the necessary support during their transition, transfer, and discharge. As service providers: We ensure the people using our service experience consistency and continuity when leaving our services. We work alongside each person and whānau to provide and coordinate a supported transition of care or support.	FA	There were documented policies and procedures to ensure discharging or transferring residents have a documented transition, transfer, or discharge plan, which includes current needs and risk mitigation. Planned discharges or transfers were coordinated in collaboration with the resident (where appropriate), family/whānau and other service providers to ensure continuity of care.
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 buildings, plant, and equipment are fit for purpose at Glenwood Home and comply with legislation relevant to the health and disability services being provided. The building warrant of fitness expires on 1 May 2026. The environment is inclusive of people's cultures and supports cultural practices. There is a maintenance person three days a week or more if required. A monthly maintenance plan is documented, implemented, and include annual calibration of medical equipment, checking performance of six ceiling hoists and testing and tagging of electrical equipment (last March 2025). The records were reviewed to be all up to date. Weekly hot water temperatures are completed across the facility and evidence to be within the appropriate parameters. The warrant of fitness is not current.
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.	PA Low	There is an infection, prevention, and antimicrobial programme and procedure that has been developed by an external aged care consultant and their infection control specialists, including the pandemic plan. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team, and training and education of staff. Policies and procedures are reviewed annually by the consultant who

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.		collaborates with infection control coordinators. The infection control programme now links to the quality programme. The infection control programme is planned to be reviewed annually; however, this has not been evidenced for 2024. Staff education includes (but is not limited to): standard precautions; isolation procedures; hand washing competencies; and donning and doffing personal protective equipment (PPE). Education has been provided to staff in 2025; however, was not provided in 2024 (link 2.3.3).
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 Moderate	Infection surveillance is an integral part of the infection control programme and is described in the infection control policy manual. Monthly infection data has been collected for all infections since February 2025 based on signs, symptoms, and definition of infection. Infections are entered into the register on the recently implemented electronic database and surveillance of all infections is collated onto a monthly infection summary. This data is monitored and analysed for trends, monthly. Benchmarking now occurs against national reporting. The service incorporates ethnicity data into surveillance methods and data captured around infections. Infection control surveillance is discussed at quality management meetings and staff meetings. Meeting minutes and graphs are displayed for staff. Action plans are required for any infection rates of concern. Internal infection control audits are completed with corrective actions for areas of improvement since February 2025. The service receives regular notifications and alerts from Health New Zealand. Staff (HCA's and RN's) report there was a Covid 19 outbreak and a norovirus outbreak last year prior to October 2024; however, there is no evidence of records to support this. The infection control coordinator (interim clinical manager) advised on interview that Infections, including outbreaks, are reported, and reviewed, so improvements can be made to reduce healthcare acquired infections (HAI). Education includes monitoring of antimicrobial medication, infection control and cultural safety aseptic technique, and transmission-based precautions. There have been no outbreaks since the current interim general manager started in October 2024.

Subsection 6.1: A process of restraint The people: I trust the service provider is committed to improving policies, systems, and processes to ensure I am free from restrictions. Te Tiriti: Service providers work in partnership with Māori to ensure services are mana enhancing and use least restrictive practices. As service providers: We demonstrate the rationale for the use of restraint in the context of aiming for elimination.	FA	The governance body is committed to providing a restraint free environment. The interim clinical manager (registered nurse) is the restraint coordinator and described the focus on maintaining a restraint-free environment. Restraint was understood by the staff interviewed who also described their commitment to maintaining a restraint free environment and therefore upholding the dignity of the residents under their care. At any time, restraint is considered, the facility works in partnership with Māori, to promote and ensure services are mana enhancing. At the time of the audit, there were no residents utilising restraint. There are detailed assessments, an approval process, and monitoring requirements available should these be required. Training for all staff occurs at orientation and annually, as sighted in the training records. Staff have been trained in the restraint minimisation, safe restraint practice and alternative cultural-specific interventions. Training has not been provided on management of challenging behaviour and de-escalation techniques (Link 2.3.4) . Restraint competencies are completed on orientation and annually. There are no evidence of a governance commitment to eliminating restraint (Link 2.1.2).

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 2.1.2 Governance bodies shall ensure service providers’ structure, purpose, values, scope, direction, performance, and goals are clearly identified, monitored, reviewed, and evaluated at defined intervals.	PA Moderate	Seven of the previous nine board members including the chairperson resigned following the AGM in December 2024. Since then, a new board has formed which includes members with expertise in legal, financial, cultural and management. The new board is meeting monthly and is actively working on supporting new systems to enhance resident care and staff wellbeing. Their first goal as stated by the chairperson on interview is to employ a permanent management team; however, the business plan for 2025 has not yet been documented. . The 2021- 2024 business plan could not be located.	(i).The 2021 to 2024 business plan could not be located. (ii) There is no documented current business plan for 2025.	(i). & (ii). Ensure the business goals documented, reviewed and evaluated at defined intervals. 90 days

Criterion 2.1.4 Governance bodies shall evidence leadership and commitment to the quality and risk management system.	PA Moderate	On interview the new chair of the board confirmed the interim general manager and interim clinical manager have submitted comprehensive quality and risk management reports for 2025; however, there was no evidence to support this occurred in 2024.	There was no evidence to support the reporting of quality and risk management activities to the board for 2024 or a commitment to the quality system.	Ensure quality and risk management activities including infection control and antimicrobial activities and restraint are reported to the board. 90 days
Criterion 2.2.2 Service providers shall develop and implement a quality management framework using a risk-based approach to improve service delivery and care.	PA Moderate	The new interim management have recently implemented a new quality system provided by an external consultant. Internal audits for 2025 are completed as scheduled and evidence robust corrective actions and sign off; however, 2024 internal audits were not evidenced as consistently completed. The interim management team have not yet scheduled a resident and family satisfaction survey for 2025 and there was no evidence of a survey being completed in 2024. Meetings are scheduled for 2025; however, have not been held as scheduled due to staffing commitments. Where meetings have been held, minutes demonstrate a comprehensive agenda is followed and fully documented. There is no documentation to evidence meetings were held in 2024. On interview staff confirmed the meeting for 2025; however, could not recall meetings in 2024. Staff interviewed confirm	(i). Resident and or family satisfaction surveys have not been completed in 2024 or 2025. (ii). Internal audits have not been consistently completed as scheduled in 2024. (iii). Quality objectives have not been documented for 2024 or 2025. (iv). Facility meetings have not been consistently completed in 2024 or as scheduled in 2025.	(i). Ensure annual resident and family satisfaction surveys are completed. (ii). Ensure internal as scheduled. (iii). Ensure quality objectives are documented and discussed. (iv). Ensure meetings are held as scheduled. 60 days

		discussions are held and the HCAs interviewed stated they were kept informed of all incidents/ infections or any changes and corrective actions were discussed and implemented.		
Criterion 2.3.3 Service providers shall implement systems to determine and develop the competencies of health care and support workers to meet the needs of people equitably.	PA Moderate	All staff are required to complete competency assessments as part of their orientation and annually. The interim management team are actively working on ensuring all competencies including hand hygiene, moving and handling, infection prevention and restraint are up to date. Review of the training records confirm that some staff have not yet completed all required competencies. All registered nurses and HCA's who assist with medication administration have a current medication competency.	(i). Staff have not been evidenced as completing the required restraint competencies as per the training schedule. (ii). Approximately 40% of staff have not completed hand hygiene and infection prevention annual competencies as per the education and training schedule. (iii). Sixty percent of staff have not completed moving and handling competencies.	(i). - (iii). Ensure all staff complete required competencies as per the training schedule. 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 Moderate	There is an annual education and training schedule being implemented for 2025; however, there was no evidence of a schedule being implemented in 2024. The 2025 education and training schedule lists compulsory training, which includes cultural awareness training and topics related to caring for the older person. Interim management identified 15 mandatory areas of training and have made these topics available to all staff via an online platform. At the	(i). A 2024 training schedule was not evidenced as being documented. (ii). Mandatory training has not been evidenced as provided for the following: sexuality/intimacy, spirituality/counselling, management of challenging behaviour; restraint, skin integrity and pressure injury prevention. (iii). Mandatory training has not been completed by at least of staff	(i). Ensure an annual training schedule is documented. (ii). Ensure all mandatory training is provided for staff. (iii). Ensure all staff complete mandatory training within required timeframes.

		time of audit, not all required training has been completed, and not all two-yearly training has been provided. Training documentation reviewed evidenced compliance varied according to topics by between 20% to 60% of total staff expected to attend. The service maintains an individual manual completion register which will be transferred to the staff personnel file when completed. Training is delivered via an online learning platform, in-services, competency questionnaires, toolbox learning, and external professional development.	for the following topics: abuse and neglect; continence management; falls prevention; food safety; fire knowledge; infection prevention; code of rights and palliative care.	90 days
Criterion 2.4.5 Health care and support workers shall have the opportunity to discuss and review performance at defined intervals.	PA Low	Staff appraisals were not consistently completed in 2024, and the interim management team implemented a schedule to ensure all staff had an opportunity to discuss and review performance; however, this has not yet been fully implemented.	Three of five staff files reviewed do not have an appraisal completed within the previous twelve months.	Ensure all staff have an annual performance review. 90 days
Criterion 3.2.1 Service providers shall engage with people receiving services to assess and develop their individual care or support plan in a timely manner. Whānau shall be involved when the person receiving services requests this.	PA Low	All initial assessments and care plans are completed by a registered nurse on admission. The policy provides guidance to ensure that additional assessments including an interRAI assessment are completed within 21 days of admission and a long-term care plan is with detailed information to guide HCAs on care delivery for the residents is completed within the	(i). One of five initial long term care plans was not completed within three weeks of admission. (ii) One of five initial interRAI assessments was not completed within three weeks of admission. (iii) Three of five interRAI reassessments were not completed within required timeframes.	(i to iv) Ensure interRAI assessments, initial long term care plans, and evaluations are completed within required timeframes. 90 days

		same time period; however, this has not consistently occurred. Six monthly interRAI reassessments and long-term care plan reviews had been completed for four residents; however, these were not completed within expected timeframes (one resident had a long-term care plan completed but did not yet require an evaluation). The service was aware of documentation delays and a corrective action plan had been documented and reviewed at the time of audit with confirmation of good progress.	(iv) Three of five care plan evaluations were not completed within required timeframes.	
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 accessible in all settings and circumstances. This includes traditional healing practitioners as well as rākau rongoā, mirimiri, and karakia;	PA Moderate	The registered nurses are responsible for the development of the care plan. Assessment tools, including cultural assessments, were completed to identify key risk areas. Alerts are indicated on the resident care plan and include (but not limited to) high falls risk, weight loss, wandering, and pressure injury risks. The registered nurses interviewed understand their responsibility in relation to assessment and care planning. There are comprehensive policies in place related to assessment and care planning; however, care plan interventions did not always reflect the current needs of the resident. Healthcare assistants are knowledgeable about the care needs of the residents and the	(i). Three of five care plans reviewed do not identify goals of care. (ii). One rest home resident and two hospital residents diagnosed with diabetes did not have interventions documented for signs and symptoms of hyperglycaemia or hypoglycaemia. (iii). One hospital resident with falls risks, management of leg oedema and behavioural concerns had no interventions documented to guide staff. (iv). No interventions were documented in the care plan for one hospital resident with equipment requirements and pain. (v). No interventions were	(i). Ensure care plans document the goals of care. (ii).- (v). Ensure care plan interventions are sufficient to guide care. 60 days

(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.		family/whānau interviewed were complimentary of the care provided. Progress notes and monitoring records evidence care delivery to the residents, reflective of their needs, as described by staff during interviews and confirmed by family/whānau interviewed. The findings related to care planning relates to documentation only. The electronic resident management system includes assessments that addresses needs, values, individual preferences, and beliefs of residents; however, not all assessments were fully reflected in the residents' care plans. One of five resident care plans reviewed identified sufficient interventions to guide the resident's current care needs. Three of five care plans reviewed did not have documented goals of care as part of the care planning process.	documented in the care plan for one rest home resident with nutritional needs, a history of falls and mobility restrictions.	
Criterion 3.2.4 In implementing care or support plans, service providers shall demonstrate: (a) Active involvement with the person receiving services and whānau; (b) That the provision of service is consistent with, and contributes to, meeting the person's assessed needs, goals, and aspirations. Whānau require assessment for	PA Low	The service has access to a range of both paper-based and electronic monitoring forms. Monitoring forms included (but were not limited to): repositioning charts; food and fluid intake; restraint monitoring; weight; neurological observations; wound management; and behaviour. Review of monitoring charts identified these were utilised; however, not all charts were maintained as per care plan instructions. Wound care plans were documented electronically, and	(i). Two of two neurological charts reviewed were not completed as per policy. (ii). Six of 21 wounds were incorrectly classified in initial wound assessments.	(i). Ensure neurological observations are completed as per policy. (ii) Ensure wounds are correctly assessed and classified

support needs as well. This supports whānau ora and pae ora, and builds resilience, self-management, and self-advocacy among the collective; (c) That the person receives services that remove stigma and promote acceptance and inclusion; (d) That needs and risk assessments are an ongoing process and that any changes are documented.		dressing occurred as scheduled; however, classification of wounds were inconsistent.		90 days
Criterion 3.2.5 Planned review of a person's care or support plan shall: (a) Be undertaken at defined intervals in collaboration with the person and whānau, together with wider service providers; (b) Include the use of a range of outcome measurements; (c) Record the degree of achievement against the person's agreed goals and aspiration as well as whānau goals and aspirations; (d) Identify changes to the person's care or support plan, which are agreed collaboratively through the ongoing re-assessment and review process, and ensure changes are implemented; (e) Ensure that, where progress is different from expected, the service provider in collaboration with the person receiving services and whānau responds by initiating	PA Moderate	Long-term care plans are formally evaluated by a registered nurse every six months. The multi-disciplinary team review meetings provide evidence of collaboration with family/whanau. The care plan evaluations were not evidenced as being completed at the same time as the interRAI assessments, care plan review and MDT process. Where the progress was documented in the care plan evaluation as different from the expected outcome, there was no evidence of updates to the care plan. Not all short-term care plans in place were reviewed as per policy.	(i). Four of four care plan evaluations reviewed do not consistently report progress against goals. (ii). Short term care plans or long-term care plan updates were not documented for a resident with mobility changes and leg oedema. (iii). A short-term care plan in place for five weeks had not been evaluated.	(i). Ensure care plan evaluations report progress against goals. (ii). Ensure short term care plans are documented or long-term care plans updated for changes in care interventions. (iii). Ensure short term care plans are evaluated regularly and are closed once resolved or transferred to the long-term care plan. 60 days

changes to the care or support plan.				
Criterion 3.4.1 A medication management system shall be implemented appropriate to the scope of the service.	PA Moderate	Comprehensive medication policies are in place the align with current legislation and best practice. Staff administering medications were aware of their role and responsibilities and have all completed competencies. The controlled drug register was reviewed. Controlled drugs are stored securely in the medication room and are checked weekly as required. Legislation requires six monthly physical stocktakes; however, this was not consistently evidenced. Two signatures are required whenever controlled drug medication is checked; however, this was not consistently evidenced	(i). Three entries in the controlled drug register did not evidence two signatures. (ii). The six monthly stocktake of controlled drugs has not been documented since June 2024	(i). Ensure drug register entries evidence two signatures. (ii). Ensure six monthly controlled drug stock takes are documented as per policy. 60 days
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 (d) Reviewed and reported on annually.	PA Low	The infection control programme has been developed by an external contractor. The infection control programme includes the completion of an annual report which includes the components of data summary, interpretation, and next steps, as well as identification of measurement targets identified for the following year; however, this was not evidenced for 2024.	The infection control programme was not evidenced as being reviewed in 2024.	Ensure the infection control programme is reviewed annually. 90 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 Moderate	The infection control coordinator has attended training and on interview understands the role including surveillance definitions. The service has recently implemented an electronic quality and resident management system including new policies; however, this has not yet been fully implemented. The general manager uses information entered into the electronic system in conjunction with verbal handovers from the infection control coordinator to prepare reports for staff meetings and the board; however, this was not consistently provided in 2024 (link 2.1.4). All infections are now entered into the infection register on the electronic resident management system and reviewed by the infection control coordinator. Staff report a norovirus outbreak and a Covid 19 outbreak in 2024; however, there is no documentation to support this.	(i). Not all infections are entered into the infection register. (ii). Monthly infections are not evidenced as consistently collated and analysed in 2024. (iii). Staff report a norovirus outbreak and a Covid 19 outbreak in 2024; however, there is no documentation to support this.	(i). Ensure all infections including outbreaks are fully documented. (ii). Ensure monthly infections are collated and analysed with input from the infection control coordinator. (iii). Ensure outbreaks are managed and reported as per policy. 60 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.