The Grange Care Limited - The Grange

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:	The Grange Care Limited
Premises audited:	The Grange
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 4 August 2025 End date: 5 August 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: 20

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

The Grange is certified to provide hospital (geriatric and medical) and rest home care for up to 20 residents. There were 20 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 has been a change in management since the last audit.

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

The service addressed eight of fourteen shortfalls identified at the previous certification related to informed consent; clinical governance; implementation of the quality programme meetings; staff appraisals; evaluation of care; first aid certificates; aspects of infection control; and safe restraint use.

Improvements continue to be required around management of adverse events; timely completion of care documents; care plan interventions; monitoring of care; medication management; and the restraint approval group meetings.

This surveillance audit has identified shortfalls related to the building warrant of fitness and restraint education and competencies.

Ō tātou motika | Our rights

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

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

The Grange has a governance structure, including clinical governance that is appropriate to the size and complexity of the service provided. The business plan includes a mission statement and operational objectives which are regularly reviewed. Barriers to health equity are identified, addressed and services delivered that improve outcomes for Māori. There is a documented quality and risk management systems in place and progress is regularly evaluated against quality outcomes. There is a process for following the National Adverse Event Reporting policy, and management have an understanding and comply with statutory and regulatory obligations in relation to essential notification reporting. There is a staffing and rostering policy. Human resources are managed in accordance with good employment practice. An orientation programme and staff training plan are in place to support staff in delivering safe quality care.

Ngā huarahi ki te oranga | Pathways to wellbeing

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

The registered nurses assess, plan and review residents' needs, outcomes, and goals with the resident and/or family/whānau input. Care plans are developed and regularly evaluated. Medical notes by the contracted general practitioner and visiting allied health professionals are integrated in the resident`s file.

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 occur 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.		Some subsections applicable to this service partially attained and of low risk.

Electrical equipment has been tested and tagged as scheduled. All medical equipment has been serviced and calibrated as scheduled. The facility is reflective of residents' cultures.

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

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

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

Surveillance data is undertaken, including the use of standardised surveillance definitions, and ethnicity data. Infection incidents are collected and analysed for trends and the information used to identify opportunities for improvements. Benchmarking occurs. There had been a Covid-19 outbreak since the last audit.

Here taratahi | Restraint and seclusion

Includes four subsections that support outcomes where Services shall aim for a restraint and seclusion free environment, in which people's dignity and mana are maintained.		Some subsections applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

The governance body is committed to eliminate restraint. The restraint coordinator is the clinical care manager. The facility has two residents using bed rails 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	15	0	1	4	0	0
Criteria	0	47	0	2	6	0	0

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

Attainment against the Ngā paerewa Health and disability services standard

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

For more information on the standard, please click here.

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

Subsection with desired outcome	Attainment Rating	Audit Evidence
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 The Grange 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 no residents who identified as Māori. The service recognises Māori mana motuhake and this is reflected in the Māori health plan and in the care plan, when Māori is admitted to the service.
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 The Grange.

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 Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is displayed in English and te reo Māori. The clinical care manager interviewed, demonstrated how it is also provided in welcome packs in the language most appropriate for the resident, to ensure they are fully informed of their rights. Interviews with three family/whānau (hospital level care), and four residents (rest home) 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 Grange 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 The Grange are trained in and aware of professional boundaries, as evidenced in orientation documents and ongoing education records. Five staff were interviewed (three healthcare assistants (HCAs), one registered nurses (RN), and one cook) and management (facility manager and clinical care 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	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. The previous audit shortfall (criteria # 1.7.1) related to informed consent forms not being signed, has been addressed. Residents and family/whānau interviewed could describe what informed consent was and knew they had the right to choose. Consent forms were appropriately signed by the resident, activated enduring power of attorney (EPOA) or welfare guardians. All documentation regarding EPOA activation is on file.

or their legal representatives with the information necessary to make informed decisions in accordance with their rights and their ability to exercise independence, choice, and control.		
Subsection 1.8: I have the right to complain The people: I feel it is easy to make a complaint. When I complain I am taken seriously and receive a timely response. Te Tiriti: Māori and whānau are at the centre of the health and disability system, as active partners in improving the system and their care and support. As service providers: We have a fair, transparent, and equitable system in place to easily receive and resolve or escalate complaints in a manner that leads to quality improvement.	FA	The 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 a historic complaint in 2023, and actions taken. There have been no other complaints made in 2024 and 2025 year to date. The clinical care manager stated any concerns are promptly addressed and resolved to the satisfaction of the residents. There were no complaints from external agencies. 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 clinical care 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 clinical care 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	FA	The Grange Retirement Home & Hospital Limited operates as The Grange and is certified to provide rest home, and hospital (medical and geriatric) levels care for up to 20 residents. On the day of audit there was a total of 20 residents: ten rest home, including one resident on Accident Compensation Corporation funding [ACC]) and ten hospital level residents. All other residents were on the age-related residential care (ARRC) contract. All rooms

governance 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.		have occupational right agreements in place, and all are certified as dual purpose. Rooms are single occupancy only. There have been no significant changes made to the environment. There has been a change in the clinical care manager position since the previous audit. The service is managed by an experienced clinical care manager (registered nurse) and has been in the current role since January 2025. Prior to this role, they were employed in management roles in healthcare. The clinical care manager is supported by an executive assistant and the organisation's chief executive officer (CEO), who also oversees a sister facility. Residents and family/whānau reported satisfaction about the care, services and activities provided. The Grange is one of two aged care facilities owned by two directors and shareholders. The directors have more than 20 years experienced in the management of aged care facilities. The chief executive officer divided their time between the two facilities. The CEO is knowledgeable around contractual and legislative requirements related to managing an aged care facility. The clinical care manager reports regularly to the CEO. The CEO attends the quality improvement meetings at each facility related to day-to-day operational activities and reporting on the quality and risk management programme, including meetings; training; health and safety; infection prevention and control; staffing; internal audits; complaints (if any); cultural safety; and survey results. The CEO reports to the Board (that meets monthly). The Grange has a business plan 2024-2027 plan that includes a mission, philosophy, and objectives of the service. The business plan is regularly reviewed against set goals as part of the quality improvement meeting. The quality plan for 2024-2025 includes commitment to restraint elimination and infection control and has been signed off by the CEO. Barriers to health equity are identified, addressed, and services are delivered to improve outcomes for Māori when in care. The clinical care manager stated they had a comprehensive induction to their role; and is undertaking further professional development activities related to managing an aged care facility. There is a clinical governance policy that provides structure to communication across the organisation and incorporating safety,

		competence, evaluation, and continuous improvement. The forum for clinical governance is through the clinical lead/quality and risk meetings that are held quarterly between the two facilities (meetings sighted). The previous audit findings (criteria # 2.1.11) related to a clinical governance structure and the quality plan sign off by the owners, have been addressed.
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	The Grange is implementing a quality and risk management programme. The quality and risk management systems include performance monitoring through internal audits and through the collection of clinical indicator data. Monthly combined quality improvement/ staff meetings provide an avenue for discussions in relation to (but not limited to) quality data; health and safety; infection control/pandemic strategies; complaints; staffing; and education. Internal audits, meetings and collation of data were documented as taking place as scheduled. Corrective actions were documented where indicated to address service improvements and evidence of progress and sign off when achieved. Quality, health and safety goals and progress towards attainment are discussed at the combined quality improvement and general staff meetings. Quality data and trends are added to meeting minutes. There was evidence of high staff attendance at meetings. The previous findings (criteria # 2.2.2) related to completion of meetings, internal audits, collation, and analysis of quality data and sharing of data, have been addressed. Quality improvement projects included eliminating medication errors. Benchmarking occurs within the electronic system. Resident and family/whānau satisfaction surveys were completed in May 2025 and data was collated and analysed; outcomes were reviewed and all evidence high satisfaction on all areas of service delivery. The results were published and communicated to residents in the monthly resident meeting and quarterly family/whānau meetings. 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. The sample of adverse event forms did not always evidence that the full completion of the adverse event forms and that potential risks are identified to minimise future risks; care plans were not always updated following numerous events of the same. The adverse event forms completed evidence timely registered nurse follow up; however, the

		investigation notes had minimal information. Family /whānau was informed following the events; however, the time and date of notification was not documented in the adverse event document. The previous audit findings (criteria # 2.2.5) related to the completion of adverse event forms and the management of the related risk remains ongoing. Discussions with the clinical care manager and chief executive officer demonstrated knowledge of the National Adverse Event Reporting Policy for internal and external reporting and to notify relevant authorities in relation to essential notifications. There was one Section 31 notification reported to HealthCERT. Data evidenced that no other reporting was required to the Health Quality and Safety Commission. There has been one outbreak since the previous audit, which was notified to Public Health.
Subsection 2.3: Service management The people: Skilled, caring health care and support workers listen to me, provide personalised care, and treat me as a whole person. Te Tiriti: The delivery of high-quality health care that is culturally responsive to the needs and aspirations of Māori is achieved through the use of health equity and quality improvement tools. As service providers: We ensure our day-to-day operation is managed to deliver effective person-centred and whānau-centred services.	FA	The roster provides sufficient and appropriate coverage for the effective delivery of care and support. The clinical care manager is available full time from Monday to Friday and provides after hours on-call cover. In the absence of the clinical care manager, clinical oversight is provided by a registered nurse, with support from the facility manager (a RN) from the sister facility. Staff and residents are informed when there are changes to staffing levels, evidenced in staff interviews and meeting minutes. Floater shift can be added to the roster as acuity of residents' change. The roster reviewed evidenced that short notice absences are covered by casual staff or agency staff. There is an RN on all shifts and a stable RN workforce since 2024. There are sufficient numbers of HCAs allocated on each shift to meet the care needs of residents. There are separate kitchen staff, maintenance, and housekeeping staff to perform non-clinical tasks. Some non-clinical tasks including laundering of personal clothing and washing of dishes, are included in daily tasks performed by HCAs. Healthcare assistants interviewed stated the workload is manageable. There is an annual education and training schedule; this has been implemented to date and covers all mandatory training, as well as a range of topics (including but not limited to) related to caring for the older person; privacy and confidentiality; palliative care; skin and pressure injury management; abuse and neglect; nutrition; and hydration. Not all staff have attended the required safe restraint use and behaviour/de-escalation training

		provided (link criteria # 6.1.6). Staff reported they are provided with face to face and impromptu toolbox training. All staff are required to complete competency assessments as part of their orientation and include hand hygiene, correct use of personal protective equipment (PPE), restraint, and manual handling and transfer. Not all staff have completed the required restraint use competency (link criteria # 6.1.6). Staff who administer medication complete annual medicine competency, and a record of completion is maintained. Clinical topics include medical conditions specific to the cohort of residents at The Grange. Healthcare assistants are encouraged to attain Careerforce New Zealand Qualifications Authority training (NZQA) levels in Health and Wellbeing; 11 of 14 HCAs have attained a level 3 NZQA qualification or higher. All RNs and two enrolled nurses (ENs) 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 subcutaneous fluids, syringe driver, and interRAI assessment competency. There are eight RNs in total, including the clinical care manager, with four that 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	Six staff files (two RN, one cook and three HCAs) 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 care partners to provide a culturally safe environment for Māori. All newly employed staff have completed a three-monthly post orientation review as required by the related policies; staff who have been employed for a year or more have a current performance appraisal on file. The previous finding (criteria # 2.4.5) related to completion of three-monthly performance appraisals has been addressed.

Subsection 3.2: My pathway to wellbeing The people: I work together with my service providers so they know what matters to me, and we can decide what best supports my wellbeing. Te Tiriti: Service providers work in partnership with Māori and whānau, and support their aspirations, mana motuhake, and whānau rangatiratanga. As service providers: We work in partnership with people and whānau to support wellbeing.	PA Moderate	Five resident files were reviewed: three hospital and two rest home (including one resident on ACC funding) levels of care. The registered nurses (RN) are responsible for all residents' assessments, care planning, and evaluation of care. The assessments inform the care plans which include details to manage all medical social and cultural needs. Initial care plans are completed within twenty-four hours of admission. The initial (first) interRAI assessments and long-term care plans are completed and developed within three weeks of the residents' admission to the facility. The files reviewed evidenced the GP visits all residents within five days of admission. An interRAI assessment is not required for the resident on an ACC contract. Six-monthly interRAI reassessments were not always completed within the required timeframe and were not always completed prior to the care plan review. The resident on ACC funding had appropriate risk assessments completed, and a comprehensive long-term care plan documented. The previous finding related to meeting the contractual requirement in relation to the GPs initial visit, is addressed; however, the development of the initial and long-term care plans needs improvement, therefore corrective action relating to care planning requirements. Therefore, the previous finding related to criteria # 3.2.1 remains. Care plan interventions were documented; however, did not always have sufficient interventions to guide the staff in the care needs of the residents. Short-term care plans are developed for acute problems, such as infections, wounds, and weight loss. Care plans were not always updated following visits from allied health professional or after adverse events investigation that include instructions from health professionals, or to manage risks identified (link criteria 2.2.5). Family/whānau interviews and resident records evidenced that family/whānau are informed where there is a change in health status, GP and medication reviews, and adverse events that occurred. However, adverse events did not always document the time and date of disclosure/communications (link # 2.2.5). There is evidence of family/whānau involvement in care planning and

		documented ongoing communication of health status updates. Care plans were evaluated six-monthly and evidence progress towards the residents `goals. The previous finding related to timeframes of care plan evaluations and progress towards goals (criteria# 3.2.5) has been addressed. Routine resident reviews are completed three-monthly by the GP, or when there is a change in the health status of the residents. The GP visits weekly and as required. The GP interviewed stated that nursing staff communicates with him effectively and assessments and referrals were timely and appropriate. 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 is available at the facility. There is an electronic wound register that is maintained. The review of wound care plans evidenced comprehensive assessments and treatment plans are well documented. Monitoring and evaluation of wounds is timely and completed at appropriate intervals. Photos were taken when this was required. The finding in the previous audit related to wound chart assessments and evaluations (criteria # 3.2.4) has been addressed. The registered nurse interviewed explained that a referral is completed when additional input is needed from a wound nurse specialist. At the time of the audit there were four residents with active wounds (chronic lesions, skin tears and abrasions). There were no residents with 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. 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, and all have been completed as required. However, two of two restraint monitoring charts have not been not completed as indicated in the resident care plans. The previous finding (criteria # 3.2.4) related to monitoring of care remains. 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	Registered nurses and medication competent staff 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 robotic packs for regular medication, 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 room, locked trolley, and locked drawers in the residents' rooms. Temperature in all areas where medications are stored are monitored. Automated digital thermometers are installed in all locked drawers in the resident rooms. The medication fridge and medication room temperatures are monitored daily, and recorded temperatures were within accepted ranges; however, paper-based monthly monitoring forms of the fridge and room temperature for the months of January to July 2025 were inconsistently documented. The finding in the previous audit related to temperature monitoring (criteria # 3.4.1) will remain. All stored medications are checked monthly for expiration dates, including medications stored in the resident locked drawers. Eyedrops have been dated on opening and all within the expiry date. Regular physical checks and reconciliation of controlled drugs has been completed six-weekly and six-monthly. The finding in the previous audit related to safe storage, management of medications (creams, eyedrops and sprays), and physical checks (criteria # 3.4.1), has been addressed. 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; however, effectiveness of PRN medications was not consistently documented in the electronic medication management system and progress notes. There were

		two residents self-administering medications (inhalers). The residents have the appropriate assessment, review, and safe storage. Medication competent HCAs or RNs sign when the medication has been administered. There are no vaccines kept on site, and no standing orders are in use. 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. 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	PA Low	The environment is inclusive of people's cultures and supports cultural practices.

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.		There is no current building warrant of fitness certificate in place. A B-RaD certificate was issued in November 2024 which identifies areas of non-conformance. There is a maintenance person responsible for maintaining the building and grounds. A monthly maintenance plan is documented. Monthly maintenance checks required, including the monitoring of hot water temperatures, have not been documented between August 2024- April 2025. Annual calibration of medical equipment, checking performance of six ceiling hoists, and testing and tagging of electrical equipment (last March 2025), were completed.
Subsection 4.2: Security of people and workforce The people: I trust that if there is an emergency, my service provider will ensure I am safe. Te Tiriti: Service providers provide quality information on emergency and security arrangements to Māori and whānau. As service providers: We deliver care and support in a planned and safe way, including during an emergency or unexpected event.	FA	The security arrangements are appropriate to safeguard the residents and staff. A sufficient number of staff are first aid trained to ensure a first aider is on every shift. The previous audit finding related to first aid certificates (criteria # 4.2.4) has been addressed.
Subsection 5.2: The infection prevention programme and implementation The people: I trust my provider is committed to implementing policies, systems, and processes to manage my risk of infection. Te Tiriti: The infection prevention programme is culturally safe. Communication about the programme is easy to access and navigate and messages are clear and relevant. As service providers: We develop and implement an infection prevention programme that is appropriate to the needs, size, and scope of our services.	FA	There is 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. The clinical care manager is the infection control coordinator and has completed the required training specific to their roles and responsibilities. The previous finding related to criteria # 5.2.1 has been addressed. Policies and procedures are reviewed annually by the consultant who collaborates with the infection control coordinator. The infection control programme links to the overarching strategic direction. The quality programme and the infection control programme are reviewed, evaluated,

		and reported on annually. The pandemic plan is available for all staff and includes scenario-based training completed at intervals. Staff education includes (but is not limited to): standard precautions; isolation procedures; hand washing competencies; and donning and doffing personal protective equipment (PPE).
Subsection 5.4: Surveillance of health care-associated infection (HAI) The people: My health and progress are monitored as part of the surveillance programme. Te Tiriti: Surveillance is culturally safe and monitored by ethnicity. As service providers: We carry out surveillance of HAIs and multi-drug-resistant organisms in accordance with national and regional surveillance programmes, agreed objectives, priorities, and methods specified in the infection prevention programme, and with an equity focus.	FA	Infection surveillance is an integral part of the infection control programme and is described in the infection control policy manual. Monthly infection data is collected for all infections based on signs, symptoms, and definition of infection. Infections are entered into the register on the electronic database and surveillance of all infections (including organisms) is collated onto a monthly infection summary. This data is monitored and analysed for trends, monthly and annually. Benchmarking occurs. The service incorporates ethnicity data into surveillance methods and data captured around infections. Infection control surveillance is discussed at quality improvement and staff meetings. Meeting minutes and graphs are displayed for staff. Action plans are required for any infection rates of concern. Internal infection control audits are completed with corrective actions for areas of improvement. The service receives regular notifications and alerts from Health New Zealand. Infections, including outbreaks, are reported, and reviewed, so improvements can be made to reduce healthcare acquired infections (HAI). Education includes monitoring of antimicrobial medication, infection control, aseptic technique, and transmission-based precautions. One Covid-19 outbreak occurred since the last audit.
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	PA Moderate	The business plan and quality plan evidence commitment of the governance body to eliminate restraint. The service reported the use of current restraints at staff meetings, quality reports or owners/director meetings. Current restraint data is reported to the owners/ directors. Two hospital residents utilise bedrails as restraint at the time of audit. The previous audit related to the reporting and sharing of restraint data (criteria # 6.1.4) has been addressed. Restraint authorisation consent forms are signed by the EPOAs. Restraint assessments are completed, and monitoring guidelines are included in the

use of restraint in the context of aiming for elimination.		care plans and are documented electronically in the resident management system; however, there is no evidence of review by the restraint approval group as per policy. The previous finding related to the approval group meetings (criteria # 6.1.5) remains ongoing. Restraint use competencies have not been completed as part of orientation or following the restraint education, as evidenced in five of the six files reviewed. Behaviour management and de-escalation training in March 2025 has only been attended by four HCAs and three RNs.
Subsection 6.2: Safe restraint The people: I have options that enable my freedom and ensure my care and support adapts when my needs change, and I trust that the least restrictive options are used first. Te Tiriti: Service providers work in partnership with Māori to ensure that any form of restraint is always the last resort. As service providers: We consider least restrictive practices, implement de-escalation techniques and alternative interventions, and only use approved restraint as the last resort.	FA	There is a restraint register. Two hospital residents utilise bedrails as restraint at the time of audit. The clinical care manager is the restraint coordinator. Restraint authorisation consent forms are signed by the EPOAs. Restraint assessments are completed that include risks, interventions to manage restraint use, and describing the frequency and extent of monitoring related to identified risks. The previous finding (criteria # 6.2. 4) related to the documentation of assessments, risks, interventions, and monitoring requirements has been addressed. However, the implementation of the monitoring as required in the care plans were not always completed (link 3.2.4).

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 2.2.5 Service providers shall follow the National Adverse Event Reporting Policy for internal and external reporting (where required) to reduce preventable harm by supporting systems learnings.	PA Moderate	Discussions with the clinical care manager and chief executive officer demonstrated knowledge of the National Adverse Event Reporting Policy for internal and external reporting and to notify relevant authorities in relation to essential notifications. There was one Section 31 notification reported to HealthCERT. Data evidenced that no other reporting was required to the Health Quality and Safety Commission. Fifteen electronic adverse events were reviewed; ten were not fully completed as guided by the adverse event management policy. Risks were not updated in the care plans where there was occurrence of the same event.	Ten of fifteen adverse event forms were not fully completed to evidence sufficient investigation notes, corrective actions to manage risks, and the time/date of relative notifications.	Ensure adverse events forms is fully completed to evidence comprehensive investigation notes, corrective actions to minimise risks, and the time/date of family/whānau notifications. 60 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 Moderate	All residents had an initial assessment and care plan developed by a registered nurse in partnership with the resident and family/whānau within 24 hours of admission; however, contractual requirements in relation to development and evaluation of long-term care plans were not consistently met. Resident's health and personal care needs are assessed on admission in order to establish an initial care plan to cover a period of up to 21 days. Initial interRAI assessment is completed (as required) and the long-term care plan is developed, documented, and evaluated by a registered nurse within 21 days of the resident's admission. Long-term care plans are reviewed following the six-month interRAI reassessment by a registered nurse and amended where necessary, to ensure it remains relevant to address the resident's current identified needs and health status.	(i). Two hospital level care residents had long-term care plans evaluated between twenty and forty-six days after interRAI assessments were completed. (ii). One hospital level care resident's interRAI assessment dates did not align with the evaluation dates of long-term care plan. (iii). One rest home level care resident's long-term care plan was completed before interRAI assessments.	(i). Ensure timely evaluation of long-term care plans following the completion of interRAI assessments. (ii). – (iii). Ensure interRAI assessments are completed prior to the development and evaluation of long-term care plans. 60 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	PA Moderate	Policies related to assessment and care plan development and evaluation are comprehensive. The registered nurses are responsible for completing assessments (including interRAI), developing resident centred care interventions, and evaluating the care delivery six-monthly, or earlier as residents' needs change. The service	(i). Three hospital level care residents were identified with recurrent urinary tract infections; however, the long-term care plans of the residents have no preventive measures, nor signs and symptoms that the resident may exhibit to alert staff that an	(i). -(iv). Ensure care plan interventions have sufficient detail to guide care. 60 days

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; (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.		requests input from multidisciplinary team (allied health and specialist services); however, care plans are not consistently updated to reflect the care needs of the residents after the review. Risks assessments are completed to identify key risk areas. Alerts are indicated in the care plan and include (but not limited to) high falls risk; high choke risk; risk for recurrent infection; and behaviours that challenge; however, the care plan interventions do not describe in sufficient detail the early warning signs and preventative measures appropriate to the identified risks (falls prevention measures, supervision required for choking risks, and signs and symptoms to monitor for urinary tract infections). Supplementary documentation reviewed and interviews with residents, family/whānau and care staff identified that the shortfalls noted relates to documentation only and the residents receive the required care. The registered nurses interviewed understand their responsibility in relation to assessment and care planning.	infection is developing. (ii). One rest home level care resident and one respite care resident under ACC were identified as high falls risk, but have insufficient falls prevention measures in the care plans, such as exercise plan as per physiotherapist and reduction of environmental risk (clutter in the room is minimised). (iii). One rest home level care resident had anxiety and self-isolation tendency but there were insufficient care plan interventions in place (i.e. identify triggers of anxiety and non-pharmacological interventions). (iv) One hospital level care resident with multiple choking episodes was reviewed by SLT; however, recommendations were not added in the care plan. Corrective actions in the adverse events form for the choking episodes are also not reflected in the care plan	
Criterion 3.2.4 In implementing care or support plans, service providers shall demonstrate:	PA Moderate	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	Two residents utilise bed rails, and restraint monitoring forms indicated that there were periods that restraint is applied more than the specified timeframe, as	Ensure the restraint monitoring forms are completed as indicated in the care plan and policy.

(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 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.		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. Restraint monitoring is not properly completed according to the resident care plan and policy in relation to time period in which the restraint is applied, and observations which focus on the resident experience (comfort, dignity and impact, communication and support, nutrition and hydration, toileting and personal hygiene, exercise, medication, and equipment).	specified in the care plan, and resident experience is not always documented when restraint is used.	60 days
Criterion 3.4.1 A medication management system shall be implemented appropriate to the scope of the service.	PA Moderate	Registered nurses are responsible for the temperature monitoring of the treatment room and medication fridge daily. The paper-based monthly monitoring records were reviewed from January 2025. The monitoring of the fridge and room temperature for the months of January to July 2025 were inconsistently documented. Pro ne nata (PRN) medications are charted in alignment with legislation and best practice; however, review of administered PRN medications for effectiveness were not consistently	(i). The medication room and medication fridge temperatures were inconsistently monitored. (ii). Ten out of ten medication charts reviewed indicate the administration of prn medications; however, effectiveness was not documented in the medication electronic system or progress notes.	(i). Ensure fridge and medication room temperature monitoring occurs daily as required. (ii). Ensure that effectiveness / outcomes of administered prn medications are documented. 30 days

		evaluated.		
Criterion 4.1.1 Buildings, plant, and equipment shall be fit for purpose, and comply with legislation relevant to the health and disability service being provided. The environment is inclusive of peoples' cultures and supports cultural practices.	PA Low	There is no current building warrant of fitness in place. There is a building warrant of fitness report and declaration (B-RaD) which identifies areas of non-conformance. Medical equipment is calibrated and checked for performance. There is a maintenance plan which requires monthly internal and external building checks, including the monitoring of hot water temperatures. There were no records of the monthly checks completed between August 2024 and April 2025.	(i). There is no current building warrant of fitness in place. (ii). Monthly maintenance checks required, including the monitoring of hot water temperatures, have not been documented between August 2024- April 2025.	(i). Ensure the maintenance plan is implemented as required; and (ii). Ensure a current building warrant of fitness certificate is displayed. 365 days
Criterion 6.1.5 Service providers shall implement policies and procedures underpinned by best practice that shall include: (a) The process of holistic assessment of the person's care or support plan. The policy or procedure shall inform the delivery of services to avoid the use of restraint; (b) The process of approval and review of de-escalation methods, the types of restraint used, and the duration of restraint used by the service provider; (c) Restraint elimination and use of alternative interventions shall	PA Moderate	A review of all restraint related processes (assessment, de-escalation, appropriateness, effectiveness) must be conducted by a restraint approval group as per policy. There are two residents that use bedrails as restraint; however, there is no evidence that these have been reviewed by the restraint approval group of the facility.	There was no evidence of approval group meetings as per restraint policy requirements.	Ensure to conduct restraint approval group meetings and minutes are documented as per policy. 60 days

be incorporated into relevant policies, including those on procurement processes, clinical trials, and use of equipment.				
Criterion 6.1.6 Health care and support workers shall be trained in least restrictive practice, safe practice, the use of restraint, alternative cultural-specific interventions, and de-escalation techniques within a culture of continuous learning.	PA Low	There is a restraint policy that provides guidance in the management of any restraint use. Staff are required to complete restraint use competency two-yearly. The files reviewed evidence staff have not completed the competency assessment as part of their orientation, nor after the restraint education in March 2025.	(i). Restraint use competencies have not been evidenced as completed as part of the Orientation Employee Induction – Clinical Self-Directed Learning Quizzes and Competencies policy, or following the restraint education, as evidenced in five of the six files reviewed. (ii) Behaviour management and de-escalation training in March 2025 has only been attended by four HCAs and three RNs.	(i). Ensure the restraint use` staff competency assessments are completed as required for all staff. (ii). Ensure education attendance related to behaviour management and de-escalation has been attended by all staff. 90 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.