McKenzie Healthcare Limited - McKenzie HealthCare

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: McKenzie Healthcare Limited

Premises audited: McKenzie HealthCare

Services audited: Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care

Dates of audit: Start date: 21 August 2025 End date: 22 August 2025

Proposed changes to current services (if any):

Total beds occupied across all premises included in the audit on the first day of the audit: 69

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

McKenzie HealthCare is certified to provide hospital (geriatric and medical), dementia and rest home levels of care for up to 82 residents. There were 69 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 and staff. The GP was not available to partake in the audit.

The service is in the process implementing and embedding the new resident management system and suite of policies. There were no changes to beds since the previous audit. The clinical manager role is vacant. Clinical oversight is provided by the general manager (registered nurse) and clinical governance and quality manager (registered nurse).

The healthcare assistants` workforce has remained stable within the facility.

There are quality systems and processes are documented. 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 has addressed one of the shortfalls identified in the previous audit in relation to antimicrobial monitoring. Shortfalls related to aspects of the quality and risk; care planning and medication management remain ongoing.

This surveillance audit has identified shortfalls related to implementation of other aspects of the quality programme, dementia training and the environment.

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 strategic plan. A Pacific health plan is in place which ensures cultural safety for Pacific peoples, embracing their worldviews, cultural, and spiritual beliefs. McKenzie Healthcare 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 (HDC) 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 low risk.

McKenzie Healthcare has a governance structure, including clinical governance that is appropriate to the size and complexity of the service provided. The strategic 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. The service has effective quality and risk management systems in place that take a risk-based approach 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. 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 demonstrate service integration. Interventions are documented address medical, physical, psycho-social, and cultural

needs. Resident files included medical notes by the contracted general practitioners or nurse practitioner and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. The registered nurses and medication competent healthcare assistants are responsible for administration of medicines. They complete annual education and medication competencies. The medicine charts reviewed met prescribing requirements.

The kitchen caters 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.

There is an annual maintenance plan that includes electrical testing and tagging, resident's equipment checks, call bell checks, calibration of medical equipment, and monthly testing of hot water temperatures. Visual checks of all electrical appliances belonging to residents are checked when they are admitted. Testing and tagging of resident`s electrical equipment is completed annually.

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 two outbreaks documented and managed 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.		Subsections applicable to this service fully attained.

The governance body does not demonstrate a commitment to eliminating restraint. The facility maintains a focus on ensuring care is provided in the least restrictive way possible. There are two residents using restraint. A registered nurse undertakes the restraint portfolio and drives the ongoing philosophy of eliminating restraint.

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	14	0	3	2	0	0
Criteria	0	44	0	3	3	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 McKenzie Healthcare 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, strategic plan and in the care plan of a resident who 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 Pacific Health and Wellbeing Plan 2020-2025 is the basis of the McKenzie Healthcare cultural safety for Pasifika Peoples and their Fonua policy. The principles/objectives of the policy are acknowledging Pacific people by maintaining respectful relationships, creating equitable access to services, valuing families, and provide high quality health care. The policy recognises Pacific models of care and include Fonofale model of care. 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 McKenzie Healthcare.

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 general 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 six family/whānau (two hospital and four from the dementia unit), and three residents (two hospital level care and one rest home level care) 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 McKenzie Healthcare 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 McKenzie Healthcare are trained in and aware of professional boundaries, as evidenced in orientation documents and ongoing education records. Sixteen staff were interviewed; six healthcare assistants [HCAs], four registered nurses (RN), two enrolled nurse [EN], one cook, one maintenance person, one maintenance manager, sales and social media coordinator) and management (general manager, clinical governance and quality manager and assistant 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,	FA	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 the appropriate activation is on file; this was evident in the resident files reviewed of the chosen sample in the dementia unit.

keep well, and live well. As service providers: We provide people using our services or their legal representatives with the information necessary to make informed decisions in accordance with their rights and their ability to exercise independence, choice, and control.		
Subsection 1.8: I have the right to complain The people: I feel it is easy to make a complaint. When I complain I am taken seriously and receive a timely response. Te Tiriti: Māori and whānau are at the centre of the health and disability system, as active partners in improving the system and their care and support. As service providers: We have a fair, transparent, and equitable system in place to easily receive and resolve or escalate complaints in a manner that leads to quality improvement.	FA	The 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. One Health and Disability (HDC) complaint made in September 2022 has substantiated a breach. The HDC has made recommendations in May 2025 related to this complaint and corrective actions related to the complaints are still in progress. The provider was still responding to corrective actions at the time of the audit. One complaint made in November 2033 has been responded to in January 2025 and remains open. One HDC complaint made in November 2023 is still open after the provider responded in July 2025 to the provisional feedback received. This complaint remains open. There were two complaints made to Health New Zealand in 2024 (one in October 2024 and one in December 2024). One complaint of October 2024 remains open. One complaint was made through the Nationwide Health and Disability Advocacy services in July 2025. The service responded to a request on 11 August 2025 which remains open. The complaints register reviewed evidence other three complaints made since the last audit. Complaints documentation reviewed included follow up and outcome letters demonstrated that complaints are being managed in accordance with guidelines set by HDC. The general manager and clinical governance and quality manager are 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 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 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.	FA	McKenzie HealthCare, located in Geraldine, is certified to provide dementia, rest home and hospital levels of care for up to 82 residents. Of the 82 beds identified as being certified, 10 dual purpose beds are for residents living in the independent units; 18 identified as being for residents with dementia requiring a secure unit; and 54 as available for residents requiring hospital or rest home (dual purpose) level of care. There are no double/ shared rooms. On the days of audit there were 69 residents in total: 41 at hospital level care, including two residents funded under an Accident Compensation Contract short- term (ACC) and 13 residents at rest home level of care; 15 residents in the secure dementia wing. There were no hospital or rest home level of care residents in the 10 dual purpose beds in the independent unit. All other residents were funded under the Age-Related Residential Care Services Agreement (ARRC). McKenzie HealthCare is privately owned by a governance body which consists of five directors who maintain regular contact with the general manager. The governance body is accountable to the residence, family/whānau, and staff by leading, coordinating and supporting the general manager to provide effective quality management systems that enable McKenzie HealthCare to demonstrate they meet the legislative requirements. There is a strategic plan 2024-2027 in place. The strategic plan includes a mission statement and operational objectives with site specific goals. One of the directors was interviewed and stated that they visit the site on a regular basis and actively engages with residents and staff, as evidenced through observations and interviews with the residents and staff. The director interviewed and the monthly directors report received from the general manager evidenced a commitment towards the implementation of the quality programme discussing significant events related to health and safety, safe staffing, complaints management

		including recommendations from HDC, infections, any outbreaks, benchmarking, call bell response, staff education/training, maintenance and financial indicators. The operational goals in the strategic plan support outcomes to reduce barriers to services and achieve equity for Māori. There are quality improvement meetings implemented as a forum where aspects related to clinical governance and the quality and risk management plan is discussed. This meeting is chaired by the clinical governance and quality manager. From this report a monthly directors report is developed for discussions; however, the quality improvement meetings (and full staff meetings) do not evidence discussion or data related to restraint and antimicrobial usage. Therefore, there is no data related to restraint or antimicrobial usage reported in the directors' report (link 2.2.2). The clinical manager role is vacant since August 2024. A new clinical manager has been appointed and will commence employment on 1 September 2025. The new clinical manager is a comprehensive nurse, experienced in the management of an aged care facility. The general manager (registered nurse) has been in the general manager role since June 2022; however, has acted in a combined role as the general manager/clinical manager in the absence of an appointed clinical manager. The full-time clinical governance and quality manager (registered nurse) has been in their role since January 2025; however, has experience in governance roles. The general manager holds a post graduate qualifications in infection control and prevention and wound management.
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	PA Low	McKenzie Healthcare is implementing a quality and risk management programme. The provider moved recently (May 2025) to another electronic resident management system is in the process to embed a newly adopted suite of policies and resident management system. The quality and risk management systems include performance monitoring through internal audits; however, records related to the internal audit schedule, completed internal results and related corrective actions were not available for April 2024 to April 2025 to review. There was no evidence in meeting minutes that staff received feedback related to audit results or

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.		related corrective actions. Since May 2025, the internal audit has been completed as scheduled. Corrective actions related to outstanding matters from meetings were documented where indicated to address service improvements and evidence of progress and sign off when achieved. The previous finding related to meeting minutes and related corrective actions (criteria # 2.2.3) have been addressed. Meeting minutes reviewed evidence that not all aspects of the performance of the quality system are discussed with staff and the directors. The previous quality, health and safety goals and progress towards attainment are discussed at quality improvement meetings and general staff (full) meetings. There was evidence of high staff attendance at meetings. Quality improvement projects included improvement of communication including building relationship with Health New Zealand, effective complaints management and call bell response. Reporting on these are evident in the relevant meetings and directors report. Monthly internal and external benchmarking of quality data, including ethnicity trends, provide a critical analysis to organisational practice and to improve health equity. The residents and family/whānau survey completed in May 2025 evidence satisfaction with service delivery with (not limited to): privacy and dignity (95%), communication (89%), care, (96%), environment (97%), how to make a complaint (73%), staff listening (84%), responding to concerns (80%) and activities (78%). All areas have showed an improvement on the previous years survey; however, the responses to the engagement of activities in the dementia remain low, this was also observed on the days of the audit. The low engagement in activities of the dementia unit is documented as an area to improve on, as documented in operation reports and directors reports/meetings. An external consultant has been involved in assisting with identifying strategies to improve the activities programme and therefore improve the engagement. The outcomes/findings were not yet available to the directors. Corrective actions include also include a roster review of the activities coordinators. The unannounced OPCAT audit completed in February 2025 provided satisfactory comments related to the dementia unit. 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, evidenced in a sample of twenty accident/incident records reviewed. Incident and accident data is collated monthly and analysed. Results are discussed in the RN/clinical meetings and at handover. Each event involving a resident reflected a clinical assessment and a timely follow up by an RN. Any risks are identified with action plans to minimise future risks. Discussions with the general manager and clinical governance and quality manager evidenced awareness of their requirement to notify relevant authorities in relation to essential notifications. There were events notified under Section 31 and the required severity assessment code (sac) reports to the Health Quality and Safety Commission have been completed. There have been two outbreaks reported since the previous audit. Both were well managed, reported as required.
Subsection 2.3: Service management The people: Skilled, caring health care and support workers listen to me, provide personalised care, and treat me as a whole person. Te Tiriti: The delivery of high-quality health care that is culturally responsive to the needs and aspirations of Māori is achieved through the use of health equity and quality improvement tools. As service providers: We ensure our day-to-day operation is managed to deliver effective person-centred and whānau-centred services.	PA Low	There is staffing requirements policy and procedure that describes rostering and staffing rations in an event of residents' acuity change and outbreak management. The general manager uses a rostering tool (sighted) that reflects a skill mix and evidence effort is undertaken to ensure staff are replaced when sick. The general manager works Monday to Friday and oversees the day to day operations and clinical oversight. The clinical governance and quality manager works Monday – Thursday (40 hours) and provide support with the implementation of the quality and risk programme and quality improvement projects. The two managers share the clinical after hours on call roster. They are supported by a 24/7 RN availability in the dual-purpose unit. The HCAs reported they felt supported, and the workload is manageable. The roster takes into consideration the design of the building. There are two ENs that support service delivery. An enrolled nurse oversees the secure dementia unit most of the week mornings. There is a RN allocated to work in the dementia unit for all afternoon shifts. The roster evidence sufficient HCAs allocated to the roster to ensure residents are well supported. There are separate staff dedicated to activities, kitchen, cleaning, and laundry services. There is currently not an activities coordinator overseeing in the dementia unit; the

		meaningful activities programme is overseen by the general manager. The clinical governance and quality manager oversees the education attendance and training schedule. There is an annual education and training schedule being implemented. The education and training schedule lists compulsory training, which includes (but not limited to) cultural awareness training; nutrition and hydration; complaints management, build collegial relationships with Health New Zealand, communication strategies, critical thinking and reporting (using STOP WATCH/ISBAR tool), timely responding to care, continence management (including colostomy care), elder abuse and neglect, Code of Rights, dementia topics, behaviour management and de- escalation, restraint management and adverse event documentation Staff last attended cultural awareness training at their orientation in October 2024. Training and education reports are completed monthly, training include face to face, completion of self-directed learning and external speakers visiting the facility (educator from Health New Zealand, continence advisor, aged concern, National health and Disability Advocate). Staff attendance is monitored and evidence high attendance numbers. There are training/ education and resources available within the online documentation library. Registered nurses are supported with opportunities though Healthlearn and have completed critical thinking, early sepsis management/ deterioration of the adult patient (DEWS), quality framework, palliative care. Registered nurses and HCAs complete annual competencies (sighted) related to their roles. There are 10 of the 12 RNs that have interRAI competencies. One enrolled nurse is interRAI trained. The service supports and encourages HCAs to obtain a New Zealand Qualification Authority (NZQA) qualification. There are 41 HCAs employed. Seventy one percent of HCAs have obtained a level 3 and above. There are 15 HCAs working in the dementia and seven have completed their required NZQA dementia standards, the requirements related to staff records and staff training as required in clause E4.5 has not been met. All staff are required to complete competency assessments as part of their orientation and annually and include restraint, medication, hand hygiene, manual handling and transfer and the donning and doffing of personal protective equipment (PPE). Registered nurses complete syringe driver

		training.
Subsection 2.4: Health care and support workers The people: People providing my support have knowledge, skills, values, and attitudes that align with my needs. A diverse mix of people in adequate numbers meet my needs. Te Tiriti: Service providers actively recruit and retain a Māori health workforce and invest in building and maintaining their capacity and capability to deliver health care that meets the needs of Māori. As service providers: We have sufficient health care and support workers who are skilled and qualified to provide clinically and culturally safe, respectful, quality care and services.	FA	Six staff files (two RNs, one enrolled nurse, 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 HCAs to provide a culturally safe environment for Māori. 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	Seven resident files: two hospital, two rest home (including resident under ACC), and three dementia rest home levels of care were reviewed for this audit. The registered nurses (RN) and enrolled nurses (EN) complete initial assessments and care plans within twenty-four hours upon the resident's admission to the service. The initial interRAI assessment are completed and serves as a basis to develop the first long term care plan (LTCP) within three weeks of admission; however, not all care plans of recent admissions were completed within the required timeframes. LTCPs are evaluated six monthly following interRAI reassessments or sooner if there is a change in the health status of the resident; however, not all LTCPs were evaluated in a timely manner. The previous finding related to criteria # 3.2.1 remains ongoing. The care plans goals and interventions developed are resident focused, individualised and addresses identified needs and health risks of residents. LTCP evaluations stated progress against the set goals and there is evidence of resident and family/whānau involvement in the interRAI reassessments and long-term care plans reviews and this is documented

		in the electronic management system. Other available information, such as discharge summaries, medical and allied health notes, and consultation with the resident, family/whānau or significant others are included in the resident electronic file and are taken into consideration when developing the care plan interventions. Residents in the dementia unit have behaviour assessments and behaviour monitoring charts. The LTCPs do not always include close to normal routine of the resident's usual pattern of behaviour and behaviour management strategies to assist caregivers in management of the resident behaviours. Therefore, the previous finding related to criteria # 3.2.3 remains; however, the shortfalls related to care plan interventions support residents assessed and current needs for hospital and rest home level care residents are now addressed. Short term care plans (STCPs) are utilised well acutes issues (such as infections, weight loss etc.) and monitoring of effectiveness of new medications or interventions. STCPS are reviewed in a timely manner and are closed off when issues are resolved. Interventions are transferred to LTCP when appropriate. The residents have the choice to remain with their own general practitioner (GP); thus, medical service in McKenzie Healthcare is provided by eight different GPs and a nurse practitioner (NP). Medical reviews and visits are scheduled by RN in accordance with requirements related to medical admissions, three monthly medical reviews and when acute and new health issues need to be addressed. Three monthly medical reviews include a review of the current prescribed medications of the resident; however, not all medication charts are consistently reviewed three monthly as required. There were no GPs or NP available for interview. Residents' electronic files identify the integration of medical reviews and allied health professional input into care, and a multidisciplinary team approach is evident. A physiotherapist is contracted, and dietitian is available by referral. A podiatrist visits six-weekly. Other allied health professionals involved in care include hospice, clinical nurse specialists, and medical specialists from Health New Zealand. Healthcare assistants interviewed could describe a verbal and written handover at the beginning of each shift that maintains a continuity of service delivery. Progress notes are written each shift by the HCAs. The

		RNs and ENs progress notes are comprehensive and reflect the progress (improvement or deterioration) of the resident's health status. Residents interviewed reported their needs and expectations are met, and this is confirmed and reinforced by family/whānau interviews. Family/whānau or EPOA were notified of all changes to health, including infections, accident/incidents, NP visits, medication changes, and any changes to health status. Family/whānau interviewed confirmed that they are well informed by the nursing staff. There are twenty-one current wounds at the time of audit. A sample of wounds reviewed included surgical wounds, chronic ulcers, skin tears, blisters, lacerations. graze and skin lesions. The electronic wound care plan documents the wound management plans, assessments, and evaluations, with supporting photographs. Evaluations of wounds and dressings change occur as specified in the plans. Referrals are completed to the wound nurse specialist for additional input for complex wounds. There are five pressure injuries including one unstageable pressure injury that are consistently monitored and are healing well. Healthcare assistants interviewed stated there are adequate clinical supplies and equipment provided, including continence, wound care supplies and pressure injury prevention resources. There is also access to a continence specialist as required. Care plans reflect the required health monitoring interventions for individual residents, including repositioning; intentional grounding; food and fluid; bowel chart; blood pressure; weight; pain; behaviour; neurological observations and blood sugar levels. Monitoring charts reviewed were completed as scheduled.
Subsection 3.4: My medication The people: I receive my medication and blood products in a safe and timely manner. Te Tiriti: Service providers shall support and advocate for Māori to access appropriate medication and blood products. As service providers: We ensure people receive their medication and blood products in a safe and timely manner that complies with current legislative requirements and safe	PA Moderate	Policies around medication administration and management are documented. All staff (registered nurses, enrolled nurses, and medication competent HCAs) who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided. Staff were observed to be safely administering medications. Healthcare assistants could describe their role regarding medication administration. All medications are checked on delivery against the medication chart and any discrepancies are fed back to the supplying pharmacy.

practice guidelines.		Medications were appropriately stored across two treatment rooms. The temperature monitoring of all treatment rooms and medication fridge was completed daily, and readings were within the acceptable ranges. All medications, including the bulk supply order are checked weekly. The date of opening of medications with a short shelf life was noted. Fifteen electronic medication charts were reviewed (sample extend by one). The is evidence of GP medication chart reviews; however, not all medication charts have been reviewed three monthly. Each chart has photo identification and allergy status identified and no residents self-administer their own medications. There is a policy documented within the medication policies to include the procedure for staff to follow should a resident wish to self-administer medication. No standing orders are in use. Pro re nata (PRN) medications are charted in accordance with prescribing requirements and administered when required; however, not all administered prn medications were monitored for effectiveness or outcome. This is an ongoing shortfall. Residents and family/whānau are updated around medication changes, including the reason for changing medications and side effects. This is documented in the progress notes.
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 nutritional assessments and is notified of any dietary changes. 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 which expires in August 2026. 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	FA	Planned discharges or transfers were coordinated in collaboration with residents and family/whānau to ensure continuity of care and to manage associated risks. Resident change, transfer, or termination policy and procedures are documented to ensure discharge, or transfer of residents is

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.		undertaken in a timely and safe manner. The registered nurses explained the transfer between services includes a comprehensive verbal handover and the completion of specific transfer documentation.
Subsection 4.1: The facility The people: I feel the environment is designed in a way that is safe and is sensitive to my needs. I am able to enter, exit, and move around the environment freely and safely. Te Tiriti: The environment and setting are designed to be Māori-centred and culturally safe for Māori and whānau. As service providers: Our physical environment is safe, well maintained, tidy, and comfortable and accessible, and the people we deliver services to can move independently and freely throughout. The physical environment optimises people's sense of belonging, independence, interaction, and function.	PA Low	There is a current building warrant of fitness (BWOF) certificate. A maintenance leader oversees maintenance of the site, maintenance team (one full time and one part time) and contractor management. Essential contractors, such as plumbers and electricians, are available 24 hours a day, every day as required. There is an annual maintenance plan that includes electrical testing and tagging, resident's equipment checks, call bell checks, calibration of medical equipment, and monthly testing of hot water temperatures. Visual checks of all electrical appliances belonging to residents are checked when they are admitted. Testing and tagging of resident`s electrical equipment is completed annually. Checking and calibration of medical equipment, hoists and scales is completed annually. Records and asset register is kept and managed by the maintenance manager and is presented during the day of audit. The environment is inclusive of people's cultures and supports cultural practices; however, it was observed that the dementia unit did not always provide residents with freedom of movement to the outdoor area.
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	FA	There is a defined and documented infection control (IC) programme implemented that was developed with input from external IC services and reviewed annually in July 2025. The IC programme was approved by an external consultant, the general manager, clinical governance and quality manager. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles,

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.		responsibilities and oversight, the infection control team, and training and education of staff. The infection control coordinator is a registered nurse (not available on the days of the audit) who has completed infection control training in March 2025 related to their role. 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 hygiene competencies; and donning and doffing personal protective equipment (PPE). All staff have completed the required training within the last 12 months.
Subsection 5.3: Antimicrobial stewardship (AMS) programme and implementation The people: I trust that my service provider is committed to responsible antimicrobial use. Te Tiriti: The antimicrobial stewardship programme is culturally safe and easy to access, and messages are clear and relevant. As service providers: We promote responsible antimicrobials prescribing and implement an AMS programme that is appropriate to the needs, size, and scope of our services.	FA	There are GPs providing services to residents in the care of McKenzie Healthcare. Short term care plans capture antimicrobial usage quality and quantity. The infection control committee monitors the quality and quantity of antimicrobial prescribing, dispensing, and administration and occurrence of adverse effects; or identifying areas for improvement or the progress of AMS activities. This is completed as part of the annual infection control and antimicrobial stewardship review. The previous finding related to criteria # 5.3.3 has been addressed; however, AMS activities are not always evidenced as being discussed elsewhere in other meetings, shared with staff or reported to the board (link 2.2.2).
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. Meeting minutes and graphs are displayed for staff; however, meeting minutes do not evidence sharing of infection control data with staff (link 2.2.2). Action plans are required for any infection rates of concern. Internal infection control audits are completed with corrective

		actions for areas of improvement; however, there were limited evidence that this has been completed between April 2024-May 2025 (link 2.2.2). 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). Two outbreaks were documented since the last audit and records evidence these were well managed with debrief meetings and `lessons learned`.
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 does not demonstrate a commitment to eliminating restraint. There was no evidence of information provided to the board and no discussions to restraint data and restraint elimination strategies (link 2.2.2). The facility maintains a focus on ensuring care is provided in the least restrictive way possible. There are two residents using restraint. A registered nurse undertakes the restraint portfolio and drives the ongoing philosophy of eliminating restraint. The restraint policy confirms that restraint consideration and application must be made in partnership with family/whānau, and the choice of the device must be the least restrictive possible. The facility works in partnership with the resident and family/whānau to ensure services are mana-enhancing. Training for all staff occurs at orientation and annually, as sighted in the training records. Staff have been trained in the least restrictive practice, safe restraint practice, alternative cultural-specific interventions, and de-escalation techniques. Restraint competencies are completed on orientation and annually.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 2.2.2 Service providers shall develop and implement a quality management framework using a risk-based approach to improve service delivery and care.	PA Low	The quality and risk management systems include performance monitoring through internal audits; however, the internal audit schedule, completed internal results and related corrective actions were not available for April 2024 to April 2025 to review. Discussions with staff and the general manager seemed that it was completed. However, there was no evidence in meeting minutes that staff received feedback related to all the aspects of the quality management system. Since May 2025, all internal audit has been completed. The monthly directors report does not evidence reporting on restraint data/restraint elimination strategies or antimicrobial stewardship.	(i). There was limited evidence of the implementation of an audit schedule for April 2024-April 2025. (ii). Although most meetings were scheduled as completed; the content of the meetings did not always reflect that's staff are informed of every aspect of performance of the quality programme (restraint, antimicrobial stewardship (AMS), internal audit results and related corrective actions). (iii). The directors report did not evidence feedback on AMS and restraint.	(i). Ensure that the internal audit schedule is implemented as scheduled. (ii). Ensure that meeting minutes evidence that staff are informed of all aspects related to the performance of the quality programme. (iii). Ensure the directors are informed of all aspects of the performance of the quality programme. 90 days

		The service provider transition from one electronic system to another electronic system since May 2025. The policies are developed by an external consultant with its own quality framework and schedule for meetings, internal audits and education that provide confidence that the current gaps in the quality system will be addressed once the transition to the new system is fully implemented.		
Criterion 2.3.4 Service providers shall ensure there is a system to identify, plan, facilitate, and record ongoing learning and development for health care and support workers so that they can provide high-quality safe services.	PA Low	Training and education reports are completed monthly, training include face to face, completion of self-directed learning and external speakers visiting the facility (educator from Health New Zealand, continence advisor, aged concern, National health and disability advocate). Staff attendance is monitored and evidence high attendance numbers. Registered nurses are supported with opportunities though Healthlearn and have completed critical thinking, early sepsis management/ deterioration of the adult patient (DEWS), quality framework, palliative care. There are 15 HCAs working in the dementia and a spreadsheet provided evidence thirteen have completed their required NZQA dementia standards; however, seven of the staff did not have evidence of any achievement of the unit standards on their file. Two staff have been enrolled for more than 18 months.	(i). Seven HCAs who have completed their dementia unit standards had no evidence of any achievement of the unit standards on file to meet the ARRC contract clause E 4.5(f). (ii). Two of the HCAs have been enrolled for more than 18 months.	(i). Ensure HCAs working in the dementia have evidence of their achievement of the dementia unit standards on record to meet the requirements of the ARRC contract. (ii). Ensure that the healthcare assistants are enrolled to complete the relevant unit standards within 18 months of them starting to work in the dementia unit. 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 Moderate	All assessments and care plans are completed by a RN in partnership with the resident and family/whānau. All files reviewed had initial interRAI assessments and reassessments completed required timeframes. The initial care plan and long-term care plan were developed (twenty days after admission) and evaluated (every six months); however, not all care plans were completed within the required timeframes. Two residents recently admitted had long term care plans developed and one resident's long term care plan was reviewed after twenty-four and sixteen days of the required timeframe respectively and one care plan have been commenced but not completed.	(i). The first long term care plans of two recent admissions (one rest home and one dementia levels of care) were developed after twenty-four days of the required timeframe. (ii). A long-term care plan of a hospital level resident was out of date by sixteen days. (iii). A long-term care plan of a resident in the dementia unit has been started, however, not all sections of the care plan have been completed.	(i). – (iii). Ensure care plans are developed and reviewed within the required timeframes 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 support worker undertakes the development of the care or support plan; (c) Comprehensive assessment includes consideration of people's lived	PA Moderate	Resident's care plan with dementia is based on the resident's assessment and includes a description of the resident's current abilities, level of independence, identified, needs/deficits, habits, routines and behavioural characteristics. Care plans must include prevention-based strategies for minimising episodes of challenging behaviours; a description of how the behaviour of the resident is best managed over a twenty-four-hour period; and a description of the activities that meet the resident's needs in relation to individual diversional,	There were no twenty-four-hour diversional plans developed for three resident files reviewed in the dementia unit (sample extended by one).	Ensure twenty-four-hour diversional therapy plan is developed for residents in the dementia unit. 60 days

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.		motivational, and recreational therapy during the twenty-four-hour period. These activities must, to the extent clinically appropriate, reflect the resident's former routines and activities that are still familiar to the resident. Resident files reviewed in the dementia unit did not have no twenty-four diversional therapy plans developed.		
Criterion 3.4.1 A medication management system shall be implemented appropriate to the scope of the service.	PA Moderate	McKenzie Healthcare has medication policies and procedures documented that align with current legislation and best practice. An electronic medications system is utilised. All medication charts are documented appropriately and include photographic identification, allergies and sensitivities are all documented clearly; however, not all	(i). Incidental sample was done by reviewing a completion report. Incidental sample evidenced that eleven medication charts are not reviewed by the GP every three months. (ii). Seven out of fifteen medication charts reviewed indicate administration of prn medications;	(i). Ensure the GP completes three monthly reviews of medication charts. (ii). Ensure that effectiveness / outcomes of administered prn medications are

		medication charts are reviewed by the GP three monthly. All medication charts sampled evidence of prn administration; however, review of administered PRN medications for effectiveness were not consistently documented.	however, effectiveness was not consistently documented in the medication electronic system or in the resident progress notes.	documented. 60 days
Criterion 4.1.1 Buildings, plant, and equipment shall be fit for purpose, and comply with legislation relevant to the health and disability service being provided. The environment is inclusive of peoples' cultures and supports cultural practices.	PA Low	There is a current Building Warrant of Fitness certificate. Maintenance records are maintained. During visual inspection of the dementia unit, the door in the lounge/dining room that leads to the outdoors were locked on two occasions.	The door from the lounge/dining room in the dementia unit leading to the outdoors were locked.	Ensure the door in the lounge/dining room leading to the outdoors stays unlocked to optimise independence. 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.