Heritage Lifecare Limited - St Joseph's Lifecare

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:	Heritage Lifecare Limited
Premises audited:	St Joseph's Lifecare
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: 28 August 2025 End date: 29 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: 84

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

St Joseph's Lifecare is owned and operated by Heritage Lifecare Limited and provides services for up to 87 residents requiring hospital (medical and geriatric), rest home, and dementia level of care. On the day of the audit there were 84 residents.

This surveillance audit was conducted against the Ngā Paerewa Health and Disability Services Standard 2021 and the contracts with Health New Zealand Te Whatu Ora. The audit process included the review of policies and procedures; the review of residents and staff files; observations; and interviews with residents, family/whānau, management, staff, and the general practitioner.

There have been changes in management since last audit. At time of the audit there was a relieving care home manager who is a registered nurse, with extensive experience in management. They were supported by a recently appointed clinical services manager and a regional clinical and quality manager.

There are documented quality systems and processes in place. Feedback from residents and family/whānau was positive about the care and the services provided. An induction and in-service training programme are documented for the service to provide staff with appropriate knowledge and skills to deliver care.

The area for improvement identified at the previous audit relating to informed consent has been met.

Improvements are still required in relation to complaints management; care planning including timeframes, interventions, and monitoring; medication management; and maintenance.

This surveillance audit identified areas of improvement related to business planning; the quality and risk management system; recruitment, orientation, training, and appraisal; accessibility of records; care plan evaluations; and outbreak management.

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

St Joseph's Lifecare provides an environment that supports resident rights and safe care. Staff demonstrated an understanding of residents' rights and obligations. There is a Māori health plan and a Pacific health plan. The service aims to provide high-quality and effective services and care for residents.

Residents receive services in a manner that considers their dignity, privacy, and independence. St Joseph's Lifecare provides services and support to people in a way that is inclusive and respects their identity and their experiences. The rights of the resident and/or their family/whānau to make a complaint is understood, respected, and upheld by the service. There are policies and processes that provide guidance on management of complaints in accordance with guidelines set by the Health and Disability Commission (HDC).

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 business plan includes a mission statement and operational objectives. The service has quality and risk management systems in place that takes a risk-based approach, and these systems aim to meet the needs of residents and their staff. Quality data is analysed to identify and manage trends. Internal audits, and collation of data were documented as taking place. The service complies with statutory and regulatory reporting obligations.

A health and safety system is in place. Health and safety processes are embedded in practice. Health and safety policies are implemented and monitored by the health and safety committee. Staff incidents, hazards, and risk information is collated and shared with governance each month.

There is a staffing and rostering policy documented. Policies to guide staff around human resources are documented. A role specific orientation programme and regular staff education and training plans are documented. Competencies are defined.

Ngā huarahi ki te oranga | Pathways to wellbeing

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

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

Medication policies reflect legislative requirements and guidelines. All staff responsible for administration of medication complete education and medication competencies. The electronic medicine charts reviewed met prescribing requirements and 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 are coordinated with residents and families/whānau.

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 medium or high risk and/or unattained and of low risk.

The building holds a current building warrant of fitness. There is an annual maintenance plan documented that includes electrical compliance testing, call bell checks, calibration of medical equipment, hot water temperatures, and appropriate pest control management. All medical equipment has been serviced, calibrated, and testing and tagging completed as scheduled.

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

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

The infection prevention and control and antimicrobial programme is in place and is reviewed annually. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Outbreak response plans are in place, and the service has access to personal protective equipment supplies. There have been outbreaks since the previous audit.

The infection prevention and control coordinator role is held by a registered nurse. Education related to infection prevention and control is included in the education planner.

Here taratahi | Restraint and seclusion

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

The restraint coordinator role is held by a registered nurse. The facility had no residents using restraints at the time of audit. Restraint is included as part of the education and training plan. 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	9	0	3	7	0	0
Criteria	0	34	0	4	13	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 in place which acknowledges Te Tiriti o Waitangi as a founding document for New Zealand. The service currently has residents who identify as Māori. The service is committed to respecting the self-determination, cultural values, and beliefs of Māori residents and family/whānau, and evidence is documented in the resident care plan and evidenced in practice. St Joseph's Lifecare has contacts with Māori health support people through own staff and local iwi, who provides opportunities for the service to learn about Māori customs and culture. Cultural assessments are completed for residents who identify as Māori. Interviews with eleven staff (four caregivers, one unit coordinator, four registered nurses, one kitchen manager, one health and safety representative), and four managers (regional clinical and quality manager, North Island property manager, care home manager [CHM relieving at the time of audit], and clinical services manager [CSM]) demonstrated a knowledge of implementing the principles of Te Tiriti O Waitangi to all aspects of the service.
Subsection 1.2: Ola manuia of Pacific peoples in Aotearoa The people: Pacific peoples in Aotearoa are entitled to live	FA	The Ola Manuia: Pacific Health and Wellbeing Plan 2020-2025 is the basis of St Joseph's Lifecare Pacific health plan that is in place and being

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.		implemented. The aim is to uphold the principles of Pacific people by acknowledging respectful relationships, valuing family/whānau, and providing high quality healthcare. There were residents identifying as Pasifika at the time of the audit; and Pacific staff members confirmed that the residents' family/whānau would be encouraged to be involved in all aspects of care, particularly in nursing and medical decisions. They cited satisfaction with the service and recognition of cultural needs. St Joseph's Lifecare partners with Pasifika employees to ensure connectivity within the region to increase knowledge, awareness and understanding of the needs of Pacific people.
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	Details relating to the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers Rights (the Code) are included in the information that is provided to new residents and their family/whānau. The CSM, CHM, or registered nurses discuss aspects of the Code with residents and their family/whānau on admission. The Code is displayed in multiple locations in English and te reo Māori. Residents (three hospital, one rest home), and family/whānau (one hospital and one dementia) interviewed reported that the service is upholding the residents' rights. Interactions observed between staff and residents during the audit were respectful.
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	An abuse and neglect policy is being implemented. St Joseph's Lifecare policies aim to prevent any form of institutional racism, discrimination, coercion, harassment, or any other exploitation. St Joseph's Lifecare as an organisation is inclusive of ethnicities, and cultural days are held to celebrate diversity. A staff code of conduct policy addresses the elimination of discrimination, harassment, and bullying. The St Joseph's Lifecare Māori Health plan includes strategies to abolishing institutional racism. There is a plan to ensure that staff complete education on orientation and annually as per the training plan on how to identify abuse and neglect (link

		2.3.4). Staff are educated on how to value the older person, showing them respect and dignity. All residents and family/whānau interviewed confirmed that the staff are very caring, supportive, and respectful. Police checks are completed as part of the employment process. The service implements a process to manage residents' comfort funds. Professional boundaries are defined in job descriptions. Interviews with registered nurses and caregivers confirmed their understanding of professional boundaries, including the boundaries of their role and responsibilities.
Subsection 1.7: I am informed and able to make choices The people: I know I will be asked for my views. My choices will be respected when making decisions about my wellbeing. If my choices cannot be upheld, I will be provided with information that supports me to understand why. Te Tiriti: High-quality services are provided that are easy to access and navigate. Providers give clear and relevant messages so that individuals and whānau can effectively manage their own health, keep well, and live well. As service providers: We provide people using our services or their legal representatives with the information necessary to make informed decisions in accordance with their rights and their ability to exercise independence, choice, and control.	FA	Six resident files reviewed included signed general consent forms. Consent forms for vaccinations were also on file where appropriate. This is an improvement on the previous audit, and the partial attainment relating to informed consent has been met. Residents and family/whānau interviewed could describe what informed consent was and their rights around choice. Admission agreements had been signed and sighted for all the files reviewed. Copies of enduring power of attorneys (EPOAs) were on resident files where applicable. EPOA activation letters were on file where appropriate, including for all residents in the dementia unit.
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	PA Low	The complaints management procedure is explained to residents and family/whānau at the time of admission. Complaint forms are readily available at the entrance, the nurses' station, and on request. Residents and family/whānau are encouraged to raise concerns in whichever way they feel comfortable, including verbal discussions, written forms, advocacy meetings, or resident meetings. The relieving care home manager maintains a complaints' register that records all verbal and written complaints. Documentation sighted, including

escalate complaints in a manner that leads to quality improvement.		follow-up letters and resolutions, shows that complaints are generally managed in line with Health and Disability Commission (HDC) guidelines. Staff are informed of complaints and any corrective actions through quality, staff, and registered nurses' meetings (link 2.2.2). Since the last audit in January 2024, there have been 14 internal complaints in 2024, six internal complaints in 2025 (year-to-date), and three external complaints referred by Health New Zealand (two in 2024 and one in 2025). Corrective actions such as re-orientation of staff and toolbox talks were documented as completed; however, a shortfall was identified related to what actions had been taken to improve services following the investigation of each complaint. The relieving care home manager was able to describe what actions had been put in place. The shortfall related to management of complaints identified at the previous certification audit remains. One HDC complaint from 2025 remains open. Information has been provided to the HDC as requested. Residents and family/whānau interviewed confirmed that the relieving care home manager is approachable, responsive, and available to address concerns promptly. Residents may involve an independent support person in the complaints process if they wish. Information about culturally appropriate support resources is available to staff to assist Māori residents and their family/whānau. The relieving care home manager acknowledged the importance of face-to-face communication and family/whānau involvement, to ensure an equitable complaints process for Māori.
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,	PA Low	St Joseph's Lifecare is owned and operated by Heritage Lifecare Limited and governed by a Board of Directors and an executive leadership team. The facility is certified to provide rest home, hospital-level (geriatric and medical), and dementia care for up to 87 beds, that include 16 secure dementia level care beds, and 71 dual purpose beds (rest home / hospital). All the beds are single occupancy. On the days of audit, there were 84 residents; 14 dementia level care; 26 rest home level of care, including one younger person with a disability (YPD); and 44 hospital level care residents, including two on respite and four on a short-term contract. Heritage Lifecare Limited is an experienced aged care provider with a well-

inclusive, and sensitive to the cultural diversity of communities we serve.		established organisational structure. The Board provides leadership, strategic guidance, and oversight of management, acting in accordance with its Board Charter. Governance meetings are held monthly, with executive team meetings occurring fortnightly. The executive team is led by the Chief Executive Officer. Directors and executives have completed education in Te Tiriti o Waitangi, health equity, and cultural safety. The organisation's Māori Network Komiti supports the implementation of culturally responsive models of care and strengthens connections with local Māori, Pasifika, and tāngata whaikaha communities. The Komiti also assists the organisation in meeting its obligations under Te Tiriti. The Kaupapa Māori Strategy, embedded within Heritage Lifecare Limited's strategic plan, reflects leadership's commitment to equity and aligns with Ministry of Health strategies. The strategic plan outlines the organisation's structure, values, purpose, scope, directions, and goals, with a clear focus on resident and whānau-centred care. Feedback from residents and tāngata whaikaha is actively sought through surveys and meetings, collated, and used to identify barriers and improve outcomes. St Joseph's Lifecare has its own business plan, which includes quality and operational goals; however, goals have not always been reviewed as scheduled. Site-specific goals focus on high-quality care, financial performance, improved food services, resident satisfaction, dementia-friendly initiatives, sustainability and social responsibility. Following a site health check, a 2025 risk management plan is being implemented. This plan includes embedding Ngā Paerewa, addressing environmental risks, staff training and compliance, workforce shortages, monthly monitoring, and quality data analysis with follow-up actions. Heritage Lifecare Limited operates a Clinical Advisory Group (CAG) chaired by the General Manager of Operations. Membership includes Regional Clinical Quality Managers, the Head of Quality & Compliance, invited advisors, with the CEO and Head of Learning & Development as ex-officio members. The group meets bi-monthly to oversee the review of evidence-based clinical policies, monitor service delivery, and drive quality improvement. At St Joseph's Lifecare, the care home manager has responsibility for embedding the quality programme. Outcomes and corrective actions are

		discussed through multiple forums, with high-risk areas escalated to senior national leaders. The programme includes site-specific risk and clinical reports, prepared by the care home manager and clinical services manager, and monitored nationally. The relieving care home manager, a registered nurse, has been in the role for six weeks during recruitment for a permanent appointment. They have two years of experience with Heritage Lifecare Limited and have a background in both clinical and management roles. The clinical services manager resigned in late June 2025, and the regional clinical and quality manager has been providing interim clinical oversight. At the time of audit, the newly appointed clinical services manager was on their third day of orientation, bringing senior clinical leadership experience from another aged care provider. The management team is supported by a unit coordinator, the regional clinical and quality manager, and the General Manager of Operations. The relieving care home manager has completed more than eight hours of training in aged care facility management. The clinical services manager is completing orientation under the guidance of the regional clinical and quality manager.
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	St Joseph's Lifecare has a documented 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. Clinical indicator data (eg, falls, skin tears, infections, episodes of behaviours that challenge) is collected, analysed, and benchmarked. Meetings have not been held as scheduled. When held, meeting minutes reviewed evidence quality data is shared in the quality, registered nurse, health and safety, and staff meetings. Internal audits are completed according to the annual schedule. Corrective actions are not consistently documented to address service improvements and there was not always evidence of progress and sign off when achieved. Quality and staff meetings provide an avenue for discussions in relation to (but not limited to) quality data; health and safety; infection control/pandemic strategies; complaints; compliments; staffing; and education. Resident/family satisfaction surveys are completed annually.

		The 2025 survey showed a net promoter score of -3, which was below the organisational average. Corrective action plans have been documented for areas that scored low in the survey. The results have been shared with residents. A health and safety system is being implemented, with the service having trained health and safety representatives. Hazard identification forms and an up-to-date hazard register were sighted. In the event of a staff accident or incident, a debrief process is documented on the accident/incident form. Ten accident/incident forms reviewed evidenced that the incident forms are completed in full and are signed off by a registered nurse and the clinical services manager, or care home manager. Incident and accident data is collated monthly and analysed by both the clinical services manager and care home manager. Results are discussed in the facility meetings. Discussions with the relieving care home manager evidenced their awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been Section 31 reports completed, and Severity Assessment Code (SAC) notifications completed to Health Quality and Safety Commission (HQSC). There have been one of three outbreaks which was appropriately reported (link 5.4.3).
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 Moderate	There is a documented roster in place that provides appropriate coverage for the effective delivery of care and support. A review of the rosters evidence there is a registered nurse on duty 24/7. Staff and residents are informed when there are changes to staffing levels, evidenced in interviews. Residents interviewed confirmed their care requirements are attended to. Interviews with staff confirmed that their workload is manageable in most cases; however, a review of the roster shows that some vacant shifts are not always able to be covered. There are also vacancies for activity staff, and caregivers are not always able to provide activities for residents, particularly in the dementia unit. Out of hours clinical on-call cover is shared on a rotation between the clinical services manager and unit coordinator. The relieving care home manager is on call for any operational concerns. The clinical services manager will perform the care home manager's role in their absence. The care home manager and clinical services manager are available Monday to

		Friday. The annual education and training schedule has not been implemented. The education and training schedule lists compulsory training, which includes cultural awareness training. External training opportunities for care staff include training through Health New Zealand and hospice. The service supports and encourages caregivers to obtain a New Zealand Qualification Authority (NZQA) qualification. Fifty caregivers are employed. Thirty-three caregivers have achieved a level 3 NZQA qualification or higher. Twenty caregivers work in the dementia unit; ten of whom have attained the required dementia unit standards. Ten have not completed the required unit standards and were post the 18-month period of employment. All staff are required to complete competency assessments as part of their orientation. All caregivers are required to complete annual competencies related to (but not limited to) restraint; hand hygiene; cultural safety; moving and handling; continence; and pressure injury. A record of completion is maintained. Additional registered nurse specific competencies include syringe driver and interRAI assessment competency. Twelve registered nurses (including the clinical services manager) are employed, with ten of them interRAI trained. All registered nurses are encouraged to also attend external training, webinars, and zoom training where available.
Subsection 2.4: Health care and support workers The people: People providing my support have knowledge, skills, values, and attitudes that align with my needs. A diverse mix of people in adequate numbers meet my needs. Te Tiriti: Service providers actively recruit and retain a Māori health workforce and invest in building and maintaining their capacity and capability to deliver health care that meets the needs of Māori. As service providers: We have sufficient health care and support workers who are skilled and qualified to provide clinically and culturally safe, respectful, quality care and services.	PA Moderate	There are human resources policies in place, including recruitment, selection, orientation and staff training and development. Six staff files reviewed evidenced signed employment contracts and police checking had been completed; however, reference checks and orientation were not consistently completed. Criterion 2.4.1 has been opened as a corrective action because of issues noted during review of the staff files. There are job descriptions in place for all positions that includes outcomes, accountability, responsibilities, and functions to be achieved for each position. A register of practising certificates is maintained for all health professionals. All staff who have been employed for over one year, did not have an annual appraisal completed.

Subsection 2.5: Information The people: Service providers manage my information sensitively and in accordance with my wishes. Te Tiriti: Service providers collect, store, and use quality ethnicity data in order to achieve Māori health equity. As service provider: We ensure the collection, storage, and use of personal and health information of people using our services is accurate, sufficient, secure, accessible, and confidential.	PA Moderate	Resident files and the information associated with residents and staff are retained in hard copy and electronic systems. Electronic information is regularly backed-up using cloud-based technology and password protected. There is a documented Heritage Lifecare Limited disaster management plan in case of information systems failure. However, at the time of the audit, it was confirmed that there were hard copy and electronic records with resident, staff, quality, and risk information that were missing. Subsection 2.5 has been opened as a corrective action because of issues noted related to access to some information, and documentation with losses that could not be accounted for.
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	The service uses an electronic resident management system. Registered nurses are responsible for residents' assessments, care planning, and evaluation of care. Seven resident files were reviewed: two residents at dementia level of care, four at hospital level (including one on a short-term contract, and one on respite), and one younger person with a disability (rest home level care). There is evidence of resident and family/whānau involvement in the interRAI assessments and long-term care plans. All residents have admission assessment information collated and an initial care plan completed within required timeframes. A suite of risk assessments is available on the electronic system. Appropriate risk assessments are conducted on admission. A cultural assessment has not been implemented for all residents. Not all initial interRAI assessments and initial care plans have been completed in a timely manner and the shortfall identified at the certification audit remains. Each newly admitted resident was reviewed by the general practitioner within five days in all files reviewed and the shortfall identified at the previous audit has been addressed. The care plans identify resident focussed goals, recognise Te Whare Tapa Whā and reflects a person-centred model of care. Other available information such as discharge summaries, medical and allied health notes, and consultation with resident and family/whānau or significant others, form the basis of the long-term care plans. The service supports Māori and family/whānau to identify their own pae ora outcomes through input into

		their electronic care plan. Barriers that prevent tāngata whaikaha and family/whānau from independently accessing information are identified and strategies to manage these documented. The respite resident and the resident on a short-term contract had initial assessments and a care plan on file; however, there are instances where the care plan is not sufficiently detailed to support care. The outcomes from assessments and risk assessments are not always reflected in care plans. Staff interviewed in the dementia unit were familiar with strategies for managing behaviours that challenge; however, not all residents in the dementia unit had a behaviour assessment and a behaviour plan with associated risks and supports/interventions documented. There were 42 (25 residents) wounds across the service, including skin tears, skin infection, abrasions, and skin lesions. There were two stage II pressure injuries and two unstageable pressure injuries. When wounds are due to be dressed, a task is automated on the RN daily schedule. There is wound care nurse specialist input into chronic wounds. Caregivers interviewed stated there are adequate clinical supplies and equipment provided, including continence, wound care supplies, and pressure injury prevention resources. There is access to a continence specialist as required. The previous audit shortfall related to documentation of interventions in care plans continues. Medical resident admission assessment within five days of admission were completed. The general practitioner (GP) reviews the residents at least three-monthly or earlier if required. The GPs visit twice a week and as required. One GP (interviewed) was complimentary of the communication, and the service provided. Specialist referrals are initiated as needed. Allied health interventions were documented and integrated into care plans. A podiatrist visits regularly and a dietitian, speech language therapist, older person mental health team, hospice nurse and wound care nurse specialist are available as required through Health New Zealand (NZ). Physiotherapy services are available. Caregivers interviewed could describe a verbal and written handover at the beginning of each duty that maintains a continuity of service delivery. Caregivers complete task lists that reflect within the progress notes on every shift. Registered nurses document at least daily for hospital level and at least weekly and as necessary for rest home and dementia level care residents. There is regular documented input from the GP and allied health

		professionals. There was evidence the RN has added to the progress notes when there was an incident, changes in health status. and routine RN reviews. Residents interviewed reported their needs and expectations were being met. When a resident's condition alters, the RN initiates a review with the GP. The electronic progress notes reviewed provided evidence that family/whānau have been notified of changes to health, including infections, accident/incidents, GP visit, medication changes, and any changes to health status. This was confirmed through the interviews with family/whānau. Caregivers complete monitoring charts, including observations; behaviour charts; bowel chart; blood pressure; weight; food and fluid; turning charts; intentional grounding; blood sugar levels; and toileting regime. However, not all charts evidence monitoring that occurs as scheduled. All incidents and accidents have been recorded, and the incident reports reviewed evidence timely RN follow up; however, neurological observations following unwitnessed falls have not always been completed according to the policy guidelines. The previous audit shortfall related to monitoring of care continues. New behaviours are recorded in progress notes, behaviour charts, and/or incident forms. A notification and escalation matrix are available to staff. The system escalates all alerts to the CSM and CHM and further alerts senior team members depending on the risk level. Evaluations are scheduled six-monthly and should be completed at the time of the interRAI re-assessment; however, evaluations were not seen in the files reviewed. Long-term care plans had been updated following the six-monthly multidisciplinary (MDT) meeting; however, when changes occurred earlier, the care plans were not always updated. Family/whānau are invited to attend the MDT case conference meeting. Short-term issues such as infections, weight loss, and wounds are addressed in a short-term care plan; however, there are instances where the short-term care plan had insufficient detail to provide guidance for care staff. The shortfalls identified at the previous certification audit to completion of documentation in a timely (sequential) manner, to documentation of interventions, and to monitoring of care remain. A further shortfall to completion of evaluation of care has also been identified.

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	A current medication management policy identifies all aspects of medicine management in line with relevant legislation and guidelines. A safe system for medicine management using an electronic system was observed on the day of audit. Paper based charts were in use by respite residents and those on short-term contracts and did not always meet legislative requirements. Prescribing practices are in line with legislation, protocols, and guidelines. The required three-monthly reviews by the GP were recorded. Resident allergies and sensitivities have been recorded on the electronic medication chart; however, were not recorded on the three paper-based charts reviewed. The service uses pharmacy pre-packaged medicines that are checked by the RN on delivery to the facility. All stock medications sighted were within current use by dates. A system is in place for returning expired or unwanted medication to the contracted pharmacy. The medication refrigerator temperatures and medication room temperatures are monitored daily, and temperatures are seen to be within required ranges. Medications are stored securely; however, not all medication with a short shelf life were stored in accordance with requirements. Controlled medications are stored securely; and registers reviewed adhered to legislative requirements. The staff observed administering medication demonstrated knowledge and at interview, demonstrated clear understanding of their roles and responsibilities related to each stage of medication management and complied with the medicine administration policies and procedures. The RN oversees the use of all pro re nata (PRN) medicines and documentation made regarding effectiveness in the progress notes was sighted. Current medication competencies were evident in staff files. Education for residents regarding medications occurs on a one-to-one basis by the clinical services manager or registered nurses. Medication information for residents and family/whānau can be accessed online as needed. There were no residents self-administering medication on the day of the audit. No vaccines are stored on site, and no standing orders are used. The medication policy describes use of over-the-counter medications and

		traditional Māori medications, and the requirement for these to be discussed with, and prescribed by a medical practitioner. Interview with RNs confirmed that where over the counter or alternative medications were being used, they were added to the medication chart by the GP, following discussion with the resident and/or their family/whānau. Shortfalls identified at the previous audit to controlled drugs, fridge and room temperatures and temperatures of the medication room temperatures have been addressed. Shortfalls identified at the previous audit to medications with a short shelf life and to documentation on paper-based medication charts have not been addressed.
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	There is a seasonal menu which encompasses residents' food and cultural preferences and has been reviewed by a dietitian. 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 kitchen manager interviewed reported they accommodate residents' requests. There is a verified current food control plan. 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	FA	There is a discharge, transition, and transfer policy. Transition or transfer is managed in a planned and coordinated manner and includes ongoing consultation with residents and family/whānau. The plan includes current needs and risk mitigation. Where needed, referrals are sent to ensure other health services, including specialist care, is provided for the resident. Referral forms and documentation are maintained on resident files.

support.		
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 Moderate	The buildings, plant, and equipment are fit for purpose and comply with legislation relevant to the health and disability services being provided. The environment is inclusive of people's cultures and supports cultural practices. The dementia unit is secure. There is a current building warrant of fitness. There is an annual maintenance plan that includes electrical testing and tagging, equipment checks, call bell checks, calibration of medical equipment and monthly testing of hot water temperatures. Hot water temperatures did not consistently meet the required standard and the shortfall identified at the previous audit remains.
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	The infection control programme is appropriate for the size and complexity of the service. The infection prevention and control and antimicrobial stewardship programmes are reviewed annually and is linked to the quality and business plan. Policies are available to staff. St Joseph's Lifecare has an outbreak and pandemic response plan (incorporating Covid-19), which includes preparation and planning for the management of lockdowns, screening, transfers into the facility and positive tests. Staff demonstrated knowledge on the requirements of standard precautions. The infection coordinator (registered nurse) oversees infection control and the anti-microbial stewardship programme across St Joseph's Lifecare and is responsible for coordinating/providing education and training to staff. The job description outlines the responsibility of this role. The orientation package includes specific training around hand hygiene and standard precautions. Annual infection control training is included in the mandatory in-services that are held for all staff. Staff have not completed infection control related education in the last 12 months (link 2.3.4). There is good external support from the general practitioner, and Health New Zealand

		infection control specialist.
Subsection 5.4: Surveillance of health care-associated infection (HAI) The people: My health and progress are monitored as part of the surveillance programme. Te Tiriti: Surveillance is culturally safe and monitored by ethnicity. As service providers: We carry out surveillance of HAIs and multi-drug-resistant organisms in accordance with national and regional surveillance programmes, agreed objectives, priorities, and methods specified in the infection prevention programme, and with an equity focus.	PA Low	Surveillance is an integral part of the infection control programme. The purpose and methodology are described in the infection control policy in use at the facility. The infection prevention and control coordinator uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the service. Monthly infection data is collected for all infections based on standard definitions, signs, symptoms and reporting criteria. Infection control data is entered into the infection register. The data is monitored and evaluated monthly and annually. Trends are identified and analysed, and corrective actions are established where trends are identified. However, these are not consistently followed up and signed off (link 2.2.2). There is benchmarking of infection rates with other Heritage facilities. Trends, benchmarking, along with actions and outcomes are discussed at the staff, and registered nurses' meetings. Meeting minutes and graphs are displayed for staff. The services incorporate resident ethnicity data into surveillance. Internal infection control audits are completed; however, corrective actions are not always documented or followed up on when documented (link 2.2.2). The service receives email notifications and alerts from Health New Zealand and Public Health for any community concerns. There has been one documented outbreak (gastroenteritis) in May 2025. However, two other outbreaks were not documented and reported as required (gastroenteritis June 2025 and respiratory in July 2025).
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	FA	The facility is committed to providing services to residents without the use of restraint wherever possible. Restraint policy confirms that restraint consideration and application must be done in partnership with families/ whānau, and the choice of device must be the least restrictive possible. The restraint coordinator interviewed described the focus on restraint elimination. At all times when restraint is considered, the facility works in partnership with Māori, to promote and ensure services are mana enhancing. At the time of the audit, there were no residents utilising restraint. Restraint

use of restraint in the context of aiming for elimination.		elimination is included as part of the mandatory training plan and orientation programme.

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 1.8.3 My complaint shall be addressed and resolved in accordance with the Code of Health and Disability Services Consumers’ Rights.	PA Low	The complaints management procedure is explained to residents and family/whānau at the time of admission. Review of information provided to residents and family/whānau on entry to service confirmed that information related to the complaints process is included. Corrective actions were signed off as being completed; however, evidence to confirm what documentation of actions that had been taken was not available during the audit. The auditors were not able to ascertain whether the actions actually had been completed, or if there were records that were not able to be found during the audit (link 2.5.1).	Evidence of corrective actions raised through the complaints process being implemented was not always able to be verified during the audit.	Ensure there is documentation that evidences that corrective actions have been implemented in response to complaints (not just signed off as completed). 90 days

		Residents may involve an independent support person such as advocacy services in the complaints process if they wish. This shortfall identified at the certification audit has been addressed; noting that there are still improvements required to the management of complaints.		
Criterion 2.1.2 Governance bodies shall ensure service providers' structure, purpose, values, scope, direction, performance, and goals are clearly identified, monitored, reviewed, and evaluated at defined intervals.	PA Low	The Heritage Lifecare Limited strategic plan outlines the organisation's structure, purpose, values, scope, directions, performance, and goals. St Joseph`s Lifecare has their own business plan, with documented business and quality goals. The 2024 -2025 and the 2025-2026 plan have not been reviewed quarterly. There is no evidence of progress reports of the goals.	Business and quality goals have not been reviewed quarterly since last audit to evidence progress.	Ensure review of business and quality goals occur as scheduled. 90 days
Criterion 2.2.2 Service providers shall develop and implement a quality management framework using a risk-based approach to improve service delivery and care.	PA Moderate	St Joseph's Lifecare has a documented quality and risk management programme that includes performance monitoring through internal audits and through the collection of clinical indicator data. Clinical indicator data (eg, falls, skin tears, infections, episodes of behaviours that challenge) is collected, analysed, and benchmarked. Staff, quality, and registered nurse meetings have not been held	(i). Meetings have not been held as scheduled. (ii). Corrective actions have not been documented consistently in relation to internal audits and meeting minutes reviewed. (iii). Where corrective actions were identified and documented (in relation to quality improvement indicators, internal audits, meeting minutes), there was no	(i). Ensure that meetings are held as scheduled. (ii). Ensure that corrective actions are documented for issues of concern. (iii). Ensure follow up, implementation, and sign off of corrective actions. (iv). Ensure that improvements are made as a result of issues being addressed through a practice

		monthly as scheduled since last audit. When held, meeting minutes reviewed evidence quality data is shared in the meetings. Corrective actions were not always documented related to issues of concern identified in meeting minutes or areas of non-compliance with internal audit. In instances where corrective actions were documented, there was no evidence of follow-up, implementation or sign off when completed. This was especially evident with internal audit process, meeting minutes, and quality indicator monthly reports. When internal audits had low score, there were corrective actions documented and repeat audits completed. However, when re-audits were completed, the same issues continued to be findings.	evidence of follow up, progress documentation, or sign off when completed. (iv). Repeat internal audits continued to identify the same findings as previous audits, demonstrating that there is no embedding of practice for continuous improvement.	of continuous improvement. 60 days
Criterion 2.3.1 Service providers shall ensure there are sufficient health care and support workers on duty at all times to provide culturally and clinically safe services.	PA Low	The roster provides appropriate coverage for the effective delivery of care and support, and the relieving care home manager stated that the facility adjusts staffing levels to meet the changing needs of residents. A review of the previous two weeks roster showed that there were ten caregivers shifts which were not replaced for acute absences. The rosters reviewed have activity staff working Monday to Friday, including in the dementia unit. There was no	A review of the roster showed that staff were not always covered/ replaced for short notice absences, or to support implementation of the activities programme, particularly in the dementia unit.	Recruit staff into vacant roles; and continue to actively seek out caregivers who can cover vacant shifts and provide activities for residents, particularly in the dementia unit, until permanent staff are appointed. 90 days

		evidence of activity staff rostered on the weekend, or of extra caregivers rostered in the dementia unit to ensure provision and facilitation of meaningful activities for the residents. On the days of the audit, observation in the dementia unit did not show staff facilitating meaningful activities for the residents. The relieving care home manager is actively recruiting for staff, including activity staff, but in the meantime is also having difficulty finding caregivers able to cover vacant shifts. The relieving care home manager and the regional clinical quality manager (who were both filling in for vacant roles with active recruitment in place) were not able to also fill in for caregiver or activity staff roles due to their own workloads. Residents interviewed confirmed their care requirements are attended to. Interviews with staff confirmed that their workload is manageable in most cases.		
Criterion 2.3.2 Service providers shall ensure their health care and support workers have the skills, attitudes, qualifications, experience, and attributes for the services being delivered.	PA Moderate	The service supports and encourages caregivers to obtain a New Zealand Qualification Authority (NZQA) qualification. Twenty caregivers work in the dementia unit; ten of whom have attained the required dementia unit standards as per ARRC agreement E4.5f. The remaining ten staff have not	Not all staff who are rostered in the dementia unit have completed the required unit standards as per ARRC agreement E4.5f.	Ensure staff rostered in the dementia unit have completed the required unit standards to meet the requirements of the ARRC agreement E4.5f. 90 days

		completed the required unit standards and were post the 18-month period of employment. There was no evidence to demonstrate that the staff were enrolled or progressing with the unit standards.		
Criterion 2.3.4 Service providers shall ensure there is a system to identify, plan, facilitate, and record ongoing learning and development for health care and support workers so that they can provide high-quality safe services.	PA Moderate	The service has a clearly documented education and training plan which lists compulsory training, that includes training related to (but not limited to) abuse and neglect; Code of Rights; health and safety; infection prevention and control; nutrition and hydration; wound management; falls; challenging behaviour; dementia, depression and delirium; as well as professional boundaries. Review of the records shows that staff had completed scheduled competencies. The regional CQM has focused on ensuring that all competencies (eg, first aid, syringe drivers etc) have been re-done, and all are now up to date and that there are records to confirm completion. Mandatory training had not been evidenced as completed as scheduled since the last audit.	Mandatory staff training has not been evidenced as completed as per the training plan since the last audit.	Ensure that training is completed as per the training plan. 60 days
Criterion 2.4.1 Service providers shall develop and implement policies and procedures in accordance with	PA Moderate	There are human resources policies in place with clearly documented recruitment processes. Three of six staff files reviewed included	Three of six staff files reviewed did not have evidence of refence checks completed as part of the recruitment process.	Ensure reference checks are completed for all staff.

good employment practice and meet the requirements of legislation.		evidence that reference checks were completed as part of the recruitment process.		60 days
Criterion 2.4.4 Health care and support workers shall receive an orientation and induction programme that covers the essential components of the service provided.	PA Moderate	There are policies in place that include orientation and staff training and development requirements. One of six staff files reviewed included evidence of completed orientation.	There is no evidence to demonstrate that staff have completed orientation in five of six files reviewed.	Ensure that there is evidence of completed orientation for each new staff member on file. 60 days
Criterion 2.4.5 Health care and support workers shall have the opportunity to discuss and review performance at defined intervals.	PA Moderate	Six staff files were reviewed at the time of audit. Five staff files of staff who had been employed for more than a year, did not have annual appraisals completed. The one other file was for a staff who had been employed for less than one year.	Five of five staff files did not have annual appraisals completed.	Ensure that annual appraisals have been completed as scheduled. 60 days
Criterion 2.5.1 Service providers shall maintain quality records that comply with the relevant legislation, health information standards, and professional guidelines, including in terms of privacy.	PA Moderate	There is a documented Heritage Lifecare Limited disaster management plan in case of information systems failure; however, at the time of the audit it was confirmed that hard copy folders including (but not limited to) 2024 meeting minutes; internal audits; restraint reports; training records; orientation and competency records; and infection reports were missing or could not be accounted for at the facility. In addition, electronic information in the shared drive with resident, staff, quality, and risk	At the time of the audit, there were hard copy and electronic records with resident, staff and quality and risk information that was missing or which could not be located.	Ensure maintenance of quality records that complies with legislation and health information guidelines. 60 days

		records had been wiped out. The service was in the process of working with the information technology team to try and restore the electronic records. Criterion 2.5.1 has been opened as a corrective action because of issues noted during the audit related to maintenance of records. The current managers and head office are aware of the issues and are actively trying to address gaps in documentation and information.		
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	Five residents required interRAI assessments, and these have been completed within the required timeframes. Initial assessments have been developed within the required timeframes. Four of five residents who required an interRAI assessment had long-term care plans in place; however, the long-term care plan in one hospital file had not been updated based on the interRAI reassessment. Activities assessments and care plans have been completed by the activities team within three weeks of admission for three long-term residents; however, three activity plans (two dementia and one younger person with a disability [rest home]) have not been completed at the same time as the review of the care plan.	Documentation of the long-term care plan does not always align with the completion of the interRAI assessment, and the activity plans are not always reviewed at the same time as when the care plan is reviewed.	Ensure that review of the care plan occurs in a timely manner after completion of the interRAI assessment, and that activity plans are reviewed when care plans are reviewed. 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 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	PA Moderate	Assessments and care plans are recorded by the registered nurse in the electronic resident management system. The care plans are individualised and reflect resident preferences; however, not all care plan interventions were documented in sufficient detail to guide staff and others to meet the resident needs (sighted in five of seven care plans reviewed). Examples are as follows: pressure injury risk in the long-term care plan did not record the presence of active pressure injuries (one hospital resident); two care plans for dementia residents who had demonstrated challenging behaviours did not include behaviour management strategies in the long-term care plan; the activities plan for two dementia residents did not reflect a 24-hour period as per contract; one hospital resident who spoke minimal English did not have a cultural plan, nor communication strategies in the long-term care plan. Short-term care plans (STCP) are used for short-term conditions. Two short-term care plans around infections were insufficiently detailed to provide guidance for care, and one STCP had not been referenced in the long-term care plan as per policy. Not all dressings had been completed as per care plan for residents who had a wound. The actions to be taken in response to blood glucose monitoring when	Interventions to manage areas of need for individual residents were not sufficiently documented in long-term care plans.	Ensure all care plans include interventions that are current, individualised and reflect the assessed needs of each resident. 30 days

as required.		levels exceed the set range is not evident for two hospital (including one short-term care) residents. One resident on a contract for respite, and the resident on a short-term contract had initial assessments and a care plan on file. There were instances where the care plan was not sufficiently detailed to support care. The outcomes from assessments and risk assessments were not always reflected in care plans. The shortfall identified at the previous certification audit remains. The risk remains as moderate; however, the timeframe to address the corrective action has been changed from 60 to 30 days.		
Criterion 3.2.4 In implementing care or support plans, service providers shall demonstrate: (a) Active involvement with the person receiving services and whānau; (b) That the provision of service is consistent with, and contributes to, meeting the person's assessed needs, goals, and aspirations. Whānau require assessment for support needs as well. This supports whānau ora and pae ora, and builds	PA Moderate	Monitoring is scheduled on worklogs for repositioning, weight, food and fluid intake, skin, 30-minute checks, neurological observations, blood glucose monitoring, and behaviours; however, not all monitoring has been completed as directed. Monitoring of the skin has not been completed for one hospital resident with high pressure injury risk. The frequency of neurological observations following a fall had not been completed according to policy for one dementia resident and one younger person with a disability (rest	Monitoring of care has not always occurred as scheduled.	Ensure that monitoring of care occurs as scheduled. 30 days

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.		home). Thirty-minute checks on a dementia resident were not completed as documented in the long-term care plan. The shortfall identified at the previous certification audit remains.		
Criterion 3.2.5 Planned review of a person's care or support plan shall: (a) Be undertaken at defined intervals in collaboration with the person and whānau, together with wider service providers; (b) Include the use of a range of outcome measurements; (c) Record the degree of achievement against the person's agreed goals and aspiration as well as whānau goals and aspirations; (d) Identify changes to the person's care or support plan, which are agreed collaboratively through the ongoing re-assessment and review process, and ensure changes are implemented; (e) Ensure that, where progress is different from expected, the service provider in collaboration with the person receiving services	PA Moderate	Care plan evaluation should occur six-monthly in line with interRAI reassessment. The electronic system used by the service has an evaluation function; however, evaluation of long-term care plan goals has not been completed as required in three files reviewed. The resident's long-term care plans in four of the seven files reviewed were not due for evaluation.	Three of three files reviewed (one hospital, one dementia, and a younger person with a disability [rest home]), had not had LTCP goals and strategies evaluated as part of the six-monthly review.	Ensure evaluations are completed as part of the six-monthly LTCP review. 60 days

and whānau responds by initiating changes to the care or support plan.				
Criterion 3.4.1 A medication management system shall be implemented appropriate to the scope of the service.	PA Moderate	Medications are safely stored in locked trolleys and in a locked medication room. Medications with a short shelf life are dated on opening; however, these were not always stored as per manufacturer's instructions. Residents on respite and/or a short-term contract paper-based medication charts include medical officer authorisation; however, not all charts were documented as per legislation. Three paper-based medication charts did not meet the requirements of the policy related to photos, allergy and administration signing sheets (nine missing administration entries when administered in August 2025).	Three paper-based medication charts did not meet the requirements of the policy; there were no photographs of the resident to use to identify the resident, or documentation of any allergies. Documentation of administration of medication was not sighted in signing sheets.	Ensure that paper-based medication charts include photographs, and documentation of any allergies (or none known); and signing sheets accurately record any administration of medication, with a process in place to monitor that this is completed. 30 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 Moderate	Testing of electrical equipment and equipment calibration is completed as required. Maintenance request books evidence sign-off following completion of each request. Water temperatures in residents' rooms are recorded as part of the internal audit schedule. At the time of the audit, records reviewed evidenced that tap water in some rooms was above 45	Hot water temperatures are monitored monthly and corrective actions are taken when able; however, across March, May, June, and July there were eight instances where resident room hot water temperatures were above 45 degrees Celsius.	Ensure that water temperatures in resident rooms are below 45 degrees. 60 days

		degrees.		
Criterion 5.4.3 Surveillance methods, tools, documentation, analysis, and assignment of responsibilities shall be described and documented using standardised surveillance definitions. Surveillance includes ethnicity data.	PA Low	The service receives email notifications and alerts from Health New Zealand and Public Health for any community concerns. There are documented policies and processes on pandemic and outbreak management. There has been one documented outbreak (gastroenteritis) in May 2025, with logs, meetings and notifications completed. However, review of infection data on the day of the audit identified probable gastroenteritis related outbreak with six residents in June 2025 and probable respiratory outbreak with 19 residents affected in July 2025. There were no documented records to evidence that outbreak management processes were commenced and implemented in both cases.	There is no evidence that outbreak management processes were implemented for probable respiratory outbreak in July (19 residents) and gastro outbreak in June 2025 (6 residents).	Ensure implementation of outbreak management processes as indicated by policy. 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.