Kowhai Resthome (2002) Limited - Kowhai Rest Home

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity: Kowhai Resthome (2002) Limited

Premises audited: Kowhai Rest Home

Services audited: Residential disability services - Intellectual; Rest home care (excluding dementia care); Residential disability services - Physical

Dates of audit: Start date: 1 September 2025 End date: 2 September 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: 26

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
(blue)	Includes commendable elements above the required levels of performance	All subsections applicable to this service fully attained with some subsections exceeded
(green)	No short falls	Subsections applicable to this service fully attained
(yellow)	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

Kowhai Rest Home is privately owned and located in Christchurch. The service is certified to provide rest home and residential disability (physical and intellectual) services level of care for up to 28 residents. There were 26 residents on the days of audit.

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

The service is managed by a recently appointed facility manager (registered nurse), supported by the owners/directors, and wider team. Residents and family/whānau interviewed spoke positively about the service provided.

The service has addressed all of the previous certification and provisional audit findings relating to the quality programme including review of policies, job description, orientation, menu review, fridge and freezer temperatures, and emergency management.

Shortfalls identified at the previous audit relating to care planning and medication systems remain.

This surveillance audit identified improvements required around complaint management, governance, the quality programme, staff education, staff appraisals, assessments, care planning and monitoring of care, and to the facility.

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

Kowhai Rest Home 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. Kowhai Rest Home provides services and support to people in a way that is inclusive and respects their identity and their experiences. The service listens and respects the voices of the residents and effectively communicates with them about their choices. Care plans accommodate the choices of residents and/or their family/whānau. There is evidence that residents and family/whānau are kept informed. The rights of the resident and/or their family/whānau to make a complaint is understood, respected, and upheld by the service.

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 effective quality and risk management systems in place that take a risk-based approach, and these systems meet the needs of residents and their staff. Internal audits, and the collection/collation of data were documented as taking place as scheduled. Quality and risk performance is reported in management and staff meetings. The service complies with statutory and regulatory reporting obligations.

Health and safety processes are implemented with this itemised as a regular agenda item at all meetings. Contractors and staff are orientated to health and safety processes.

There is a staffing and rostering policy documented. Human resources are managed in accordance with good employment practice. A role specific orientation programme and regular staff education and training are in place. Staff are suitably skilled and experienced. Competencies are defined and monitored.

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 nurse assesses residents on admission. InterRAI assessments and risk assessments are used to identify residents' needs, and long-term care plans are developed and implemented. Residents who identify as Māori or Pasifika have their needs met in a manner that respects their cultural values and beliefs. Resident files included medical notes by the general practitioner and visiting allied health professionals.

Residents' food preferences and dietary requirements are identified at admission, and all meals are cooked on site. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met. The service has a current food control plan.

Medication policies reflect legislative requirements and guidelines. The registered nurse, enrolled nurse and medication competent caregivers are responsible for administration of medicines. They complete annual education and medication competencies. The electronic medicine charts reviewed met prescribing requirements and were reviewed at least three-monthly by the general practitioner.

Discharge and transfers are coordinated and planned.

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 has a current warrant of fitness. Hot water temperatures are monitored, and all equipment is tagged, tested, and calibrated as scheduled. Bedrooms are personalised.

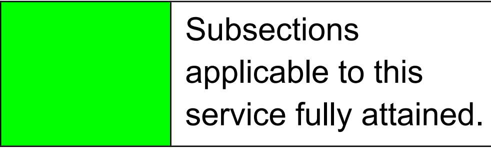
Te kaupare pokenga me te kaitiakitanga patu huakita | Infection prevention and antimicrobial stewardship

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.

The infection prevention and control programme is implemented and has been approved by the owner/directors.

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. Staff are informed about infection control practices through meetings, and education sessions. There have been no outbreaks since the previous 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.

Restraint minimisation and safe practice policies and procedures are in place. Restraint minimisation is overseen by the facility manager. At the time of the audit there were no residents using physical restraints. Staff demonstrated a sound knowledge and understanding of providing the least restrictive practice, de-escalation techniques, and alternative interventions.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Subsection	0	11	0	2	6	0	0
Criteria	0	44	0	4	9	0	0

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

Attainment against the Ngā paerewa Health and disability services standard

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

For more information on the standard, please click here.

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

Subsection with desired outcome	Attainment Rating	Audit Evidence
Subsection 1.1: Pae ora healthy futures Te Tiriti: Māori flourish and thrive in an environment that enables good health and wellbeing. As service providers: We work collaboratively to embrace, support, and encourage a Māori worldview of health and provide high-quality, equitable, and effective services for Māori framed by Te Tiriti o Waitangi.	FA	A Māori health plan is 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 facility manager identifies as Maori and has comprehensive knowledge of te ao Māori. The service is committed to respecting the self-determination, cultural values, and beliefs of Māori residents and whānau and evidence is documented in the resident care plan and evidenced in practice. Kowhai Rest Home has an established linkage with a Māori provider (Te Waka Tapu) and links are established with the other kaumatua via Kowhai Rest Home Māori staff and residents for activities such as blessing of the rooms. Comprehensive cultural assessments are completed for residents who identify as Māori. Interviews with six staff (four caregivers, the enrolled nurse and the cook) and the facility manager 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 and enjoy good health and wellbeing. Te Tiriti: Pacific peoples acknowledge the mana whenua of	FA	The Pacific Health and Wellbeing Plan 2020-2025 is the basis of the Kowhai Rest Home Pacific health plan. The aim is to uphold the principles of Pacific people by acknowledging respectful relationships, valuing families, and providing high quality healthcare.

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.		There were residents identifying as Pasifika at the time of the audit. Interviews with the facility and staff members confirmed that family/whānau are 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. Kowhai Rest Home 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 Code of Rights are included in the information that is provided to new residents and their family/whānau. The facility manager discusses 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. Four residents (two using rest home level of care and two with physical disability), and three family/whānau (one using rest home level of care and two with physical disability) confirmed that individual choices, independence and cultural beliefs are respected. Interactions observed between staff and residents during the audit were respectful. Family/whānau of younger persons with disability identified that staff put residents, family/whānau and the community at the centre of their services and this was confirmed by residents interviewed.
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. Kowhai Rest Home policies aim to prevent any form of institutional racism, discrimination, coercion, harassment, or any other exploitation. Kowhai Rest Home as a facility is inclusive of ethnicities, and cultural days are held to celebrate diversity. A staff code of conduct is discussed during the new employee's induction to the service with evidence of staff signing the code of conduct policy. This code of conduct policy addresses the elimination of discrimination, harassment and bullying. 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 residents of all ages including younger people with physical and intellectual disability,

		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 management and staff confirmed their understanding of professional boundaries, including the boundaries of their role and responsibilities. Professional boundaries are covered as part of orientation.
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	Five resident files reviewed included signed general informed consent forms. Consent forms for vaccinations were also on file where appropriate. 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 seen. Copies of enduring power of attorneys (EPOAs) were on resident files where applicable.
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	PA Moderate	The complaints management procedure is provided to residents and family/whānau on entry to the service. The facility manager maintains a record of all complaints, both verbal and written by using a complaint register. Documentation including follow-up letters and resolution demonstrates that complaints are not always being managed in accordance with guidelines set by the Health and Disability Commissioner (HDC). A complaints register is being maintained. There have been three complaints received since the previous audit in January 2025; however,

improvement.		these had not been entered on the complaints register and there was no evidence of associated documentation including follow-up letters and resolution to demonstrate that complaints are being managed in accordance with guidelines set by the Health and Disability Commissioner. The complaints procedure is provided to residents and families during the resident's entry to the service. The Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers Rights (the Code) is visible, and available in te reo Māori, and English. Discussions with residents and families/whānau confirmed that they were provided with information on the complaints process. The facility manager is responsible for the management of complaints and provides Māori residents with support to ensure an equitable complaints process. The facility manager acknowledged the understanding that, for Māori, there is a preference for face-to-face communication and confirmed that this would be encouraged for any complainant, but particularly for Māori. Residents and family/whānau making a complaint can involve an independent support person or advocate in the process if they choose. Information about the support resources for all residents including Māori is available to staff to assist with understanding the complaints process. Interpreter`s contact details are available.
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.	PA Moderate	Kowhai Rest Home is the trading name of Kowhai Rest Home (2002) Limited - a privately owned company since 2002 which has two owner/directors. The company is registered in compliance with legislative, contractual, and regulatory requirements. There is a recently appointed facility manager (RN), supported by a RN, an experienced EN, and an experienced care team. One of the directors was previously the facility manager and resigned from the position in April but continues to be available to support the current facility manager by phone and weekly visits. The weekly reports from the facility manager include information to directors on oversight of the quality and risk system however this has not been fully documented or consistently provided to both directors. One of the directors lives locally and is in regular contact to facilitate the link between management and governance. The governance of the service is via the owner/directors, one of whom is

		available to provide onsite support to the service. Clinical governance is overseen by one of the directors (RN) in conjunction with information from the facility manager with input from the GP and wider multidisciplinary team. The facility manager is responsible for ensuring clinical matters are reported to the directors weekly via their reports and onsite visits. Kowhai Rest Home is located in south east Christchurch and provides rest home level of care and residential disability services – physical and intellectual, for up to 28 residents. On the day of the audit, there were 26 residents: 25 rest home level including two residents under the long-term support chronic health (LTS-CHC) contracts and two with individual funding agreements. One resident is using hospital level of care and the facility has a current letter of dispensation for this. There were six younger residents with physical disabilities (rest home level). The remaining residents were under the age-related residential care contract (ARRC). There were no residents identified as having intellectual disability. Kowhai Rest Home overall vision and values is documented in the business plan along with the mission statement and goals, however there is no evidence to support goals and objectives have been reviewed. All staff are made aware of the vision and values during their induction to the service. The business plan reflects a commitment to collaborate with Māori, aligns with the Ministry of Health strategies and addresses barriers to equitable service delivery. The annual quality and risk management programme reflects evidence of regular compliance and risk reporting that highlight operational goals. Outcomes and corrective actions are shared and discussed in the range of meetings that take place across the service with the local director attending these on occasions. The facility manager has experience in mental and community health and commenced employment in April 2025. Prior to this they have been employed as a rest home clinical manager for approximately two years. The facility manager has not yet completed professional development activities related to managing an aged care facility and other training.
Subsection 2.2: Quality and risk The people: I trust there are systems in place that keep me safe, are responsive, and are focused on improving my	PA Moderate	Kowhai Rest Home is implementing a quality and risk management programme. Policies and procedures are reviewed biannually and all policies including those related to infection and emergency management

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.		have been reviewed as required. The previous partial attainment related to policies (2.2.1.) has been addressed. The quality and risk management systems include performance monitoring through internal audits and through the collection of clinical indicator data. Monthly meetings include full staff, and separate management meetings. The meetings incorporate health and safety and infection control. These document the review and discussion around all areas, including (but not limited to): infection control/pandemic strategies; cultural compliance; staffing, education; quality data; health and safety; hazards; corrective actions; emergency processes; incidents and accidents; internal audits; and infections. Monthly meetings ensure good communication. Corrective actions are documented where indicated, to address service improvements; however, do not clearly identify the actions required to address the problem and do not consistently provide evidence of progress and closure. Quality data is documented in meeting minutes and accessible to all staff members. The service completes resident, family/whanau satisfaction, and food satisfaction surveys annually. The resident survey in March 2025 reflected a drop in overall satisfaction from 90% in 2024 to 75% in 2025. Survey results are analysed internally to identify areas for improvement. Results for 2025 identified concerns raised about an overall decrease in facility and room appearance and dissatisfaction by over 60% of respondents unhappy with the way staff treated them regarding dignity and respect and waiting to enter their rooms. Results have not been discussed at resident meetings and staff and directors were not informed A risk management plan is in place. Health and safety is a standing agenda item in the monthly management meetings and staff meetings. Actual and potential risks are documented on a hazard register, which identifies risk ratings, and documents actions to eliminate or minimise each risk. Staff incident, hazards and risk information is collated and analysis undertaken by the facility manager monthly and reported to the owner/director. In the event of a staff accident or incident, a debrief process is documented on the accident/incident form. There were no serious staff injuries in the last 12 months. Hard copy reports are completed for each incident/accident, and immediate action is documented with any follow-up action(s) required, evidenced in the accident/incident forms. Immediate actions are

		documented with any follow-up action(s) required, evidenced in the accident/incident forms reviewed. Incident and accident data is collated monthly and analysed. A summary is provided against each clinical indicator. Each event involving a resident, includes a clinical assessment and the timely follow up by a registered nurse. Opportunities to minimise future risks are identified by the registered nurse in consultation with the EN and caregivers. Discussions with the facility manager evidenced awareness of their requirement to notify relevant authorities in relation to essential notifications, however the FM was unaware of the severity assessment code (SAC) reporting procedures. There have been four occasions requiring Section 31 notifications since January 2025. This included notification of the change of facility manager. There have been no outbreaks since the previous audit .
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 a staffing policy that describes rostering requirements, and the service provides adequate registered nurse cover for rest home level care residents. The registered nurse and a selection of caregivers hold current first aid certificates. There is a first aid trained staff member on duty 24/7. The facility manager is available Monday to Sunday and covers the on-call roster. Interviews with caregivers, the enrolled nurse and the facility manager confirmed that their workload is manageable. Staff and residents are informed when there are changes to staffing levels, evidenced in staff interviews, staff meetings and resident meetings. There is an annual education and training schedule; this has been implemented to date and covers all mandatory training as well as a range of topics related to caring for the older person; however, staff completion of training for 2024 and 2025 is low. 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. Kowhai rest home’s orientation programme ensures core competencies and compulsory knowledge/topics are addressed. The RN has a syringe driver and interRAI assessment competency.

Subsection 2.4: Health care and support workers The people: People providing my support have knowledge, skills, values, and attitudes that align with my needs. A diverse mix of people in adequate numbers meet my needs. Te Tiriti: Service providers actively recruit and retain a Māori health workforce and invest in building and maintaining their capacity and capability to deliver health care that meets the needs of Māori. As service providers: We have sufficient health care and support workers who are skilled and qualified to provide clinically and culturally safe, respectful, quality care and services.	PA Low	There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. There are job descriptions in place for all positions that includes outcomes, accountability, responsibilities, authority, and functions to be achieved in each position. Five staff files reviewed included a signed employment contract, job description, police check, orientation documentation relevant to the role the staff member is in, application form and reference checks. The previous partial attainment related to job descriptions has been addressed. As per policy, all staff who have been employed for over one year are required have an annual appraisal completed however this was not consistently evidenced. The practising certificates for the facility manager, and other health practitioners are retained to provide evidence of their registration. An orientation/induction programme provides new staff with relevant information for safe work practice. Competencies are completed at orientation as required for all files reviewed. The previous partial attainment has been addressed. 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. The service demonstrates that the orientation programme supports staff to provide a culturally safe environment for Māori. Caregivers interviewed reported that the orientation process prepared new staff for their role and could be extended if required. Non-clinical staff have a modified orientation, which covers all key requirements of their role.
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.	PA Moderate	The registered nurse is responsible for all residents' assessments, care planning and evaluation of care. Five resident files were reviewed including one rest home, one hospital, one on a YPD contract (physical disability), two on a LTS-CHC contract (rest home), and one on an individual funding agreement. The file review confirmed that initial care plans are developed in partnership with the residents/EPOA within the required timeframe. There is documented evidence of resident, EPOA or family/whānau involvement in care-planning. Care plans are based on data

As service providers: We work in partnership with people and whānau to support wellbeing.		collected during the initial nursing assessments. The individualised long-term care plans are developed with information gathered during the initial assessments and the interRAI assessment, however not all interRAI assessments were completed prior to the long-term care plan. The long-term care plans for all residents sampled had been completed within three weeks of the residents' admission to the facility however the initial interRAI was not always completed within required timeframe. Documented interventions and early warning signs did not always meet the residents' assessed needs. Short term care plans are developed for short term needs such as infections, wounds, bruises and have been evaluated and signed off once completed or transferred to the long-term care plan. Three residents who have been at Kowhai Rest Home for over six months had evaluations completed which reflected progress towards goals. Advance directive plans are reviewed during care planning and have been reviewed by the GP at least annually or when significant changes in health occurred. The previous partial attainment has been addressed. Enabling good life principles for younger people with disabilities are in place and care plans reviewed reflects self-determination, is person centred and individualised to include community engagement, and family and social support. Two YPD residents interviewed stated they are involved in planning their care and own goals. The initial medical assessment is undertaken by the GP within the required timeframe following admission. Residents have reviews by the GP within required timeframes and when their health status changes. There is documented evidence of the exemption from monthly GP visits when the resident's condition is considered stable. The GP visits the facility weekly for planned reviews, and is available for acute visits, and after hours. Documentation and records reviewed were current. The GP was interviewed and stated they had confidence in the registered nurse, enrolled nurse and experienced care staff . The GP stated care staff knew the residents very well and were prompt at identifying adverse changes. A physiotherapist is available as required and there is evidence of visits to the facility in residents' records. Contact details for family are recorded in the clinical file. Resident records evidenced that family are informed where there is a change in health

		status. There was evidence of wound care products available at the facility. The review of the wound care plans evidenced wounds were assessed and reviewed however the wound management plans did not always identify frequency of dressings. Photos were taken where this was required. Wounds included chronic ulcers, blister and a lesion. There was evidence that if wounds required additional specialist input, this was initiated, and a wound nurse specialist consulted. Caregivers interviewed could describe a verbal and written handover at the beginning of each shift that maintains a continuity of service delivery, as observed on the day of audit, and was found to be comprehensive in nature. Progress notes are written each shift and as necessary by caregivers and the registered nurse. When changes occur with the residents' health, these are reflected in the progress notes to provide an evolving picture of the resident journey. When a resident's condition alters, the registered nurse initiates a review with the GP. There was evidence the registered nurse had added to the progress notes when there was an incident and or change in health status. A range of monitoring charts are available for staff to utilise; however, these were not always fully implemented as required for all residents. Monitoring charts including weight, blood glucose levels and challenging behaviours reviewed were completed as required; however, repositioning charts and neurological observations were not always completed as per policy. Long-term care plans are scheduled for formally evaluations every six months in conjunction with the interRAI re-assessments and when there is a change in the resident's condition, however not all files reviewed during the audit were completed within required timeframes. The shortfall identified at the previous audit remains. Evaluations include the degree of achievement towards meeting desired goals and outcomes, are documented by the registered nurses. Residents interviewed confirmed assessments are completed according to their needs and in the privacy of their bedrooms.

Subsection 3.4: My medication The people: I receive my medication and blood products in a safe and timely manner. Te Tiriti: Service providers shall support and advocate for Māori to access appropriate medication and blood products. As service providers: We ensure people receive their medication and blood products in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Moderate	There is a suite of medication management policies. A safe electronic medication management system was observed on the day of audit, and ten medication records were reviewed. The medication management policy identifies all aspects of medicine management in line with relevant legislation and guidelines. Prescribing practices are in line with legislation, protocols, and guidelines. Three-monthly reviews by the GP and allergies were recorded in all medication charts sampled. All resident photographs were current. The previous shortfall has been addressed. Registered nurses, the enrolled nurse and caregivers are responsible for medication administration and have current medication competencies. A registered nurse check medications on arrival against the resident`s electronic medication chart; any discrepancies are fed back to the pharmacy. Any medication errors are documented in the incident management system, collated, analysed and benchmarked. The registered nurse holds a current syringe driver competency. There is one secure cupboard within the clinic room that stores regular medications and secure medication. The service uses pharmacy pre-packaged medicines that are checked by the registered nurse on delivery to the facility. Documentation of the date opened was completed for all medication with a short shelf life. 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; however, these have not been consistently monitored as scheduled. Medications are stored securely in accordance with requirements. There is a shortfall related to documentation of effectiveness of pro re nata (PRN) medication and to prolonged continuation of a short-course medication. 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. All staff who administer medications have current competencies in place. All pro re nata (PRN) medications include the reason for administration however effectiveness of PRN medications was not consistently documented. Current medication competencies were evident in staff files. There were no residents self-administering medication on the day of the

		audit; policy and procedures including assessment, review, and the provision of safe storage was in place should there be residents who do self-administer medication. Standing orders are not used, and vaccines are not kept on site.
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	A nutritional assessment is undertaken by the registered nurse for each resident on admission to identify the residents’ dietary requirements and preferences. The nutritional profiles are communicated to the kitchen staff and updated when a resident’s dietary needs change. Diets are modified as needed and the cook at interview confirmed awareness of the dietary needs, likes, dislikes and cultural needs of residents. These are accommodated in daily meal planning. Discussion and feedback on the menu and food provided is sought at the residents’ meetings and in the annual residents’ survey. Residents and families interviewed stated that they were satisfied with the meals provided. The menu review was completed by a registered dietitian on 20 January 2025. The previous shortfall related to review of the menu has been addressed. The food control plan is current. All fridge and freezer temperatures were consistently documented as schedule and were within required ranges and the previous shortfall has been addressed.
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 documented policy that relates to resident transfer and discharge. Transition, discharge, or transfer is managed in a planned and coordinated in a timely and safe manner. Interview with staff confirmed residents and their family/whānau were involved for all discharges to and from the service. Discharge notes are kept on file and discharge instructions are incorporated into the care plan.

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	There is a building warrant of fitness certificate. Maintenance requests are logged and followed up. There is an annual maintenance plan that includes electrical testing and tagging, residents' equipment checks, call bell checks, calibration of medical equipment and monthly testing of hot water temperatures. Essential contractors such as plumbers and electricians are available 24 hours a day as required. Checking and calibration of medical equipment, hoists and scales was completed annually. Caregivers interviewed stated they have adequate equipment to safely deliver care for residents. All corridors have safety rails that promote safe mobility. Corridors are spacious, and residents were observed moving freely around the areas with mobility aids where required. There is safe access to all communal areas. A visual inspection of the facility identified areas of maintenance requiring attention. The issues identified had also been identified in an internal audit completed in January 2025. Residents are encouraged to personalise their bedrooms, including those with cultural or spiritual significance as viewed on the days of audit.
Subsection 4.2: Security of people and workforce The people: I trust that if there is an emergency, my service provider will ensure I am safe. Te Tiriti: Service providers provide quality information on emergency and security arrangements to Māori and whānau. As service providers: We deliver care and support in a planned and safe way, including during an emergency or unexpected event.	FA	The policies and guidelines for emergency planning, preparation, and response are displayed and easily accessible by staff. Civil defence planning guides direct the facility in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency. A fire evacuation plan in place was approved by the New Zealand Fire Service in 1995. A trial evacuation drill is held every six months. The staff orientation and ongoing training programme includes fire and security training. A civil defence plan was in place. There were adequate supplies in the event of a civil defence emergency, including food, water, candles, torches, continent products, gas, and a barbeque. Emergency lighting is available and is regularly tested. The service has an arrangement with a local company to provide priority access to a generator in the event of an

		emergency. The previous shortfall has been addressed. There are staff with current first aid certificates. A review of roster allocations confirmed all shifts were covered by a staff member with a current first aid certificate. The previous shortfall has been addressed. Staff confirmed their awareness of the emergency procedures.
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 prevention and control programme is appropriate for the size and complexity of the service. The programme is linked to the quality improvement programme, reviewed annually, and approved by the owners. The infection control policies were developed with input from infection control specialists and these comply with relevant legislation and accepted best practice. The enrolled nurse (EN) is the infection control coordinator. Staff interviews confirmed that infections are managed appropriately, reflecting adherence to established protocols. A review of staff training records evidenced that staff mandatory infection control and prevention training had been provided (link 2.3.4). Staff receive education in infection control at orientation and through ongoing annual online education sessions. Additional staff education around the prevention and management of infectious outbreaks is ongoing. This includes reminders about handwashing and advice to residents about remaining in their room if they are unwell. Staff who were interviewed demonstrated a good understanding of infection control and prevention measures.
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	FA	The infection surveillance program is tailored to the facility's size and service complexity, with thorough monitoring and management of infections. An infection control manual is used as reference for best practice around infection control. Advice around infection control matters is also sought from the local infection control specialist in Regional Public Health and by liaising with the GP. Monthly data on various infections, including those affecting the urinary tract, skin, eyes, respiratory system and wounds is collected, based on signs, symptoms and infection definitions. This information is logged into an infection register and detailed in a monthly infection summary, where

programme, and with an equity focus.		infections, including specific organisms, are reviewed. Subsequently, action plans are formulated and implemented, which is also analysed monthly and annually for trend identification. Additionally, the infection control data captures information on ethnicity. To support infection prevention, audits are regularly conducted, covering areas such as cleaning, laundry, use of personal protective equipment (PPE), and the procedures for donning and doffing personal protective equipment (PPE), as well as hand hygiene practices. Where necessary, corrective measures are taken. Staff are kept up to date on infection rates and outcomes of regular audits during staff meetings, with evidence documented in the minutes of these meetings. There have been no reported outbreaks since the previous audit.
Subsection 6.1: A process of restraint The people: I trust the service provider is committed to improving policies, systems, and processes to ensure I am free from restrictions. Te Tiriti: Service providers work in partnership with Māori to ensure services are mana enhancing and use least restrictive practices. As service providers: We demonstrate the rationale for the use of restraint in the context of aiming for elimination.	FA	The restraint approval process is described in the restraint policy and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of restraints. The facility manager (RN) is the restraint coordinator and provides support and oversight for restraint management in the facility. The restraint coordinator is conversant with restraint policies and procedures. The restraint coordinator described the organisation’s commitment to restraint elimination and implementation across the organisation. The reporting process to the directors includes restraint data that is gathered and analysed monthly. On the day of the audit there were no residents using any restraint. The use of restraint (if any) would be reported monthly at the facility meetings, and to the owners/directors. Interviews with staff confirmed who are actively involved in the ongoing process of restraint elimination. Training for all staff occurs at orientation and annually (link 2.3.4). This includes a competency assessment.

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 Moderate	A complaints register is in place and accurately records all complaints up until January 2025. The previous facility manager (RN director) ensured all complaints were resolved in accordance with the Code of Health and Disability Services consumer rights. The change of management and knowledge of responsibilities has contributed to the management of recent complaints.	i). Three written complaints have not been documented on the complaints register. ii). Three complaints submitted by residents do not evidence associated documentation, follow-up or resolution.	i). Ensure all complaints are documented on the complaints register. ii). Ensure all complaints are actioned in accordance with the Code. 60 days
Criterion 2.1.2 Governance bodies shall ensure service providers’ structure, purpose, values, scope, direction, performance, and goals are clearly identified, monitored, reviewed, and	PA Low	The business plan is documented for 2025 and includes a mission statement, goals and objectives and a strength, opportunities, weaknesses and threats analysis. The director interviewed advised goals and objectives are	There is no evidence that directors participate in a review of business plan goals at defined intervals.	Ensure business plan goals are monitored and evaluated at defined intervals.

evaluated at defined intervals.		reviewed annually however this was not able to be evidenced.		90 days
Criterion 2.1.3 Governance bodies shall appoint a suitably qualified or experienced person to manage the service provider with authority, accountability, and responsibility for service provision.	PA Moderate	The facility manager is a registered nurse with experience in mental and community health and has previously worked as a clinical manager in a small rest home. The facility manager is responsible for clinical oversight and sending weekly reports to the directors however they are new to the role and do not yet demonstrate a full understanding of the responsibilities of the role.	The facility manager (RN) has not had previous experience as a manager of a rest home and has not completed related professional development.	Ensure the facility manager completes relevant professional development. 60 days
Criterion 2.1.4 Governance bodies shall evidence leadership and commitment to the quality and risk management system.	PA Moderate	The facility manager is responsible for clinical oversight and sending weekly reports to the directors. Information sent to the directors includes information on occupancy, staff movements, relevant incidents, maintenance and general business; however not all relevant information has been communicated as required. On interview, the director was unaware of the status of all complaints, a number of corrective actions, survey results, ongoing maintenance issues and clinical compliance delays.	Weekly reports have not been consistently provided to both directors with all aspects of quality and risk included in the reports.	Ensure comprehensive weekly reports are provided as per schedule to both directors. 60 days
Criterion 2.2.4 Service providers shall identify external and internal risks and opportunities, including potential inequities, and develop a plan to	PA Moderate	Internal audits are completed as scheduled and identify areas of noncompliance. Corrective actions are documented and shared with staff at monthly meetings however do not consistently identify required actions.	i). Corrective actions do not always identify details of required actions, progress or of a timely resolution. ii). Corrective actions have not	i). Ensure corrective actions details required actions, progress and resolution. ii). Document

respond to them.		Several repeat audits continue to identify the same problems without documenting progress or resolution. An annual resident survey was completed in March 2025 with results analysed and compared against the previous years, however corrective actions have not been developed to address adverse responses. The survey analysis was documented and stored in the internal audit folder however results have not been shared with stakeholders	been documented for adverse survey responses. iii). Survey results have not been communicated to residents, staff or directors.	corrective actions where opportunities for improvement are identified from surveys. iii). Ensure results of surveys are communicated to residents, staff and directors. 60 days
Criterion 2.2.5 Service providers shall follow the National Adverse Event Reporting Policy for internal and external reporting (where required) to reduce preventable harm by supporting systems learnings.	PA Low	Section 31 notifications have been submitted by the RN for four incidents including theft and resident altercation. Police were involved in three of these. The manager is new to the role and is yet to develop a full understanding of the National Adverse Event Reporting Policy.	The FM was unaware of the severity assessment code (SAC) reporting procedures. They had reported a recent fracture on a Section 31 form but not a SAC report to the Health Quality and Safety Commission.	Ensure the facility manager develops an understanding of SAC reporting requirements and implement. 90 days
Criterion 2.3.4 Service providers shall ensure there is a system to identify, plan, facilitate, and record ongoing learning and development for health care and support workers so that they can provide high-quality safe services.	PA Low	An annual training plan is documented for 2025. Training policy requires all staff complete compulsory training. There is one enrolled nurse and one registered nurse; and 18 caregivers currently employed at Kowhai Rest Home. Training is provided through online internet systems and completion is monitored, with records evidencing between five and nine staff have completed courses as required in 2025. Less than 50% of staff have completed each of the following training sessions	Less than 50% of staff have attended required training in 2024 and 2025.	Ensure staff complete required training as scheduled. 90 days

		in 2025: pandemic/covid 19;health and safety; abuse and neglect; informed consent; fire and safety; code of rights; cultural safety; restraint and safe practice; infection prevention and control ; open disclosure; complaints; falls prevention; mobility and safe transfers; pressure injury prevention; wound and skin care and continence management.		
Criterion 2.4.5 Health care and support workers shall have the opportunity to discuss and review performance at defined intervals.	PA Low	Staff appraisals are scheduled annually providing staff with an opportunity to discuss performance and identify training opportunities. Five staff files were reviewed. Two staff had not been employed for a year and did not require an annual review; however annual reviews had not been completed as scheduled for three long term staff.	Three of three staff files where annual appraisals were required identified that annual appraisals are overdue.	Ensure annual appraisals are completed as scheduled. 90 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;	PA Moderate	Assessments and care plans are documented by the registered nurse. The care plans are individualised and reflect resident preferences; however, not all assessments and care plan interventions were documented in sufficient detail to guide the resident needs. Three of five resident files reviewed identified insufficient interventions to guide the resident's current care needs. Interventions (apart from interventions related to medications) were not documented for one resident on anticoagulants,	There were insufficient interventions to guide staff on current care needs in three of five files reviewed.	Ensure all care plan interventions are current, reflect the assessed needs of residents, and are available to guide care staff. 90 days

(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.		management of a fungal rash and pain management. Interventions were not documented for a resident with interRAI triggers of delirium and mood and pain management. Interventions did not record sufficient details related to delusions and hallucinations, management of diabetes, and of early warning signs of frequent lower respiratory tract infections.		
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 resilience, self-management, and	PA Moderate	Caregivers and the RNs complete monitoring charts, including bowel chart; vital signs; weight; catheter changes; blood glucose levels; and behaviour as required however not all required charts have been implemented. Policy requires completion of neurological observations for all unwitnessed falls; however, policy timeframes have not been followed as scheduled. A wound register is maintained, however review of current wounds identified management plans are not fully documented. Three of three neurological observations reviewed have not been consistently monitored	Monitoring of care is not always documented as being completed as per plans. This included completion of neurological observations, frequency of dressings, and repositioning charts.	Ensure that monitoring of care is documented and completed as per care planning. 60 days

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.		as per policy following unwitnessed falls or potential head injuries. Two of three wounds management plans do not identify dressing frequency of next review date. A repositioning chart is not documented as per the care plan instructions for a hospital resident at high risk of pressure injuries		
Criterion 3.2.5 Planned review of a person's care or support plan shall: (a) Be undertaken at defined intervals in collaboration with the person and whānau, together with wider service providers; (b) Include the use of a range of outcome measurements; (c) Record the degree of achievement against the person's agreed goals and aspiration as well as whānau goals and aspirations; (d) Identify changes to the person's care or support plan, which are agreed collaboratively through the ongoing re-assessment and review process, and ensure changes are implemented; (e) Ensure that, where progress is different from expected, the service provider in collaboration with the person receiving services and whānau responds by initiating changes to the care or support plan.	PA Moderate	The registered nurse (RN) is responsible for all residents' assessments, care planning and evaluation of care. Timeframes for completion of the documentation were not always met in the five files reviewed. One recently admitted resident does not evidence an interRAI assessment has been completed within 21 days of admission. Two of three residents requiring interRAI reassessments did not have these completed six monthly. Two residents of three care plan evaluations were not always completed six monthly. One resident had the initial interRAI assessment competed two weeks after the long-term care plan. The previous shortfall remains.	Not all documentation was completed in a timely manner including an initial and ongoing interRAI assessments, and evaluation of long-term care plans.	Ensure that interRAI assessments and care plans are completed as per contract in a timely manner. 90 days

Criterion 3.4.1 A medication management system shall be implemented appropriate to the scope of the service.	PA Moderate	There is a fridge within the clinic room for medications. Temperatures for the fridge and medication room are scheduled to be recorded daily; however, this was not always completed as planned. Temperatures sighted were within the appropriate temperature range as per policy when they were recorded. Ten medication charts were reviewed three monthly by the GP and PRN medication included a reason for administration; however, effectiveness of PRN medication given was only consistently documented in three of the files reviewed. One short course of medication was charted by the GP with the period of administration included, however this were not always discontinued as prescribed.	i). Daily temperatures of the medication room and fridge have not been consistently recorded. ii). Seven out of ten medication charts reviewed and/or progress notes did not have effectiveness of PRN medications recorded following administration of the medication. iii). A short course of medication (treatment of a fungal rash) was still being administered two weeks after the stop date.	i). Ensure temperatures of the medication room and fridge are recorded daily. ii). Ensure effectiveness of PRN medications is recorded. iii). Ensure short course medications are stopped as per GP charting. 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 Moderate	The facility is an older style villa which provides accommodation in single rooms, a communal lounge, separate dining room and communal shower and toilet areas. A maintenance audit was completed by a contractor and sent to the director based overseas 6 July 2025. This report completed on 22 June 2025 identified areas needing repair or maintenance including the appearance of black mould in the main bathroom block and the possibility of a leak in the ceiling space. The issues were initially identified in an environmental audit in January 2025;	Visual observation and review of environmental audits identified issues with a large area black mould on the ceiling, and call bell issue in a communal bathroom. This was first identified in January 2025. Some repairs to the building were also required.	Develop a corrective action plan and complete repairs and maintenance issues identified in the January 2025 environmental audit. 7 days

		however, repairs have not yet been started. Some of the minor areas of repair have been completed.		

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.