Orewa Beach View Retirement Home & Hospital Limited - Solemar

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:	Orewa Beach View Retirement Home & Hospital Limited
Premises audited:	Solemar
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 16 October 2025 End date: 17 October 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: 25

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 are fully attained with some subsections exceeded
	No short falls	Subsections applicable to this service are 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 are 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 are 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 are unattained and of moderate or high risk

General overview of the audit

Orewa Beach View Retirement Home and Hospital Limited - Solemar provides rest home and hospital levels of care for up to 32 residents. On day of audit there were 25 residents.

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

The facility manager is supported by the owner/director, registered nurses, caregivers, and support staff. They are supported by the quality systems and processes being implemented. Feedback from residents and families/whānau was complimentary regarding the staff and standard of care delivered. An induction programme provides staff with appropriate knowledge regarding the facility and service.

There have been no changes to the facility since the previous partial provisional audit.

The service has addressed one of the two remaining shortfalls identified at the certification audit in relation to internal audits. The shortfall around satisfaction surveys remains open.

The service has addressed the four shortfalls identified at the previous partial provisional audit relating to communication with the funder regarding two residents assessed as requiring hospital level of care remaining in the dementia unit; changing the dementia unit from secure to unsecure; the removal of locks off the bedroom doors in the dementia unit, and the evacuation scheme.

This surveillance audit identified shortfall relating to resident rights, staff training, care plan interventions, and maintenance.

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 are partially attained and of low risk.

There is a Māori health plan in place. The service recognises Māori mana motuhake, and this is reflected in the Māori health plan. A Pacific health plan is in place which ensures cultural safety for Pacific peoples, embracing their worldviews, cultural, and spiritual beliefs.

Policy and procedure guide staff to keep residents safe from abuse. There are established systems to protect resident's property and finances. The complaints process is responsive, fair, and equitable. It is managed in accordance with the Code of Health and Disability Services Consumers' Rights, and complainants are kept fully informed.

Hunga mahi me te hanganga | Workforce and structure

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

The Solemar business plan includes mission and values statements, and operational objectives that are regularly reviewed. Barriers to health equity are identified, addressed, and services are focussed to ensure outcomes are improved for Māori. The service has established quality and risk management systems that take a risk-based approach, to meet the needs of residents and their staff.

There is process for following the National Adverse Event reporting policy, and management have an understanding, and comply with statutory and regulatory obligations in relation to essential notification reporting. Quality improvement projects are implemented. Internal audits are documented as taking place as scheduled, with corrective actions as indicated.

There are staffing and rostering guidelines. Human resources are managed in accordance with good employment practice. A role specific orientation programme is in place.

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 are partially attained and of medium or high risk and/or unattained and of low risk.

The facility/clinical services manager and registered nurses are responsible for the assessments, planning and review of residents' needs, outcomes, and goals with the resident and/or family whānau input. Care plans demonstrate service integration. Resident records included medical notes 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.

The kitchen staff cater to individual cultural and dietary requirements. The service has a current food control plan.

All resident's 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 are partially attained and of low risk.

The building holds a current building warrant of fitness. A maintenance plan is in place, and all equipment has been tested, tagged and calibrated as scheduled. Hot water temperatures are maintained within the required range.

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 are fully attained.

There is a comprehensive infection control plan in place, which is reviewed annually and has been approved by the owner/director. Surveillance data is undertaken, including the use of standardised surveillance definitions. Results of surveillance are acted upon, evaluated, and reported to relevant personnel in a timely manner. There has been an outbreak recorded and reported on since the last audit.

Here taratahi | Restraint and seclusion

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

The service aims for a restraint-free environment, and this is supported by the governing body and policies and procedures. There were no residents requiring restraint at the time of audit. Staff demonstrated knowledge and understanding of providing the least restrictive practice, de-escalation techniques, and alternative solutions.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Subsection	0	14	0	3	2	0	0
Criteria	0	47	0	3	2	0	0

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

Attainment against the Ngā paerewa Health and disability services standard

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

For more information on the standard, please click here.

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

Subsection with desired outcome	Attainment Rating	Audit Evidence
Subsection 1.1: Pae ora healthy futures Te Tiriti: Māori flourish and thrive in an environment that enables good health and wellbeing. As service providers: We work collaboratively to embrace, support, and encourage a Māori worldview of health and provide high-quality, equitable, and effective services for Māori framed by Te Tiriti o Waitangi.	FA	A Māori health plan is documented for the organisation, which the service utilises as part of their strategy to embed and enact Te Tiriti o Waitangi in all aspects of service delivery. On day of audit there were residents and staff who identified as Māori. A review of the cultural aspect of a care plan showed that the care was provided equitably and based on Te Tiriti o Waitangi principles, with recognition of mana motuhake. Staff (one registered nurse, two caregivers, one cook) and one manager (facility /clinical services manager) confirmed that they have completed cultural safety training and are proficient in discussing principles of Treaty of Waitangi and applications within their roles; however, staff training in cultural safety was unable to be verified at time of audit (Link 2.3.4).
Subsection 1.2: Ola manuia of Pacific peoples in Aotearoa The people: Pacific peoples in Aotearoa are entitled to live and enjoy good health and wellbeing. Te Tiriti: Pacific peoples acknowledge the mana whenua of Aotearoa as tuakana and commit to supporting them to achieve tino rangatiratanga.	FA	Solemar uses a model of care that reflects the values and beliefs, which underpin the health service provision to Pacific people. During the audit there were staff who identified as Pasifika; there were no residents who identified as Pasifika. Staff when interviewed demonstrated a basic understanding of Pacific culture and were knowledgeable where to go to access further support and guidance if they needed it.

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.		
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.	PA Low	The Code of Health and Disability Services Consumers' Rights (the Code) is displayed in English and te reo Māori around the facility. Residents are not currently supplied with a welcome package on admission, and not all residents and family/whānau interviewed were aware of the Code. The information sharing for residents and their family/whānau requires improvement. Interviews with three family/whānau (one from rest home and two from hospital) and four residents (three hospital and one rest home) revealed that the information shared with residents and their family/whānau regarding the Code was inconsistent. Residents and family/whānau are briefed on the extent of services provided about any financial responsibilities for services not covered under the scope; all of which are detailed in the service agreement. Not all staff interviewed were knowledgeable about the Code and were unsure about how to support residents to know and understand their rights (Link 2.3.4).
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	Solemar policies guide staff to prevent any form of discrimination, harassment, or any other exploitation. A staff code of conduct is discussed during the employee's induction to the service, with evidence of staff signing the code of conduct policy. There are established policies, and protocols to respect resident's property, including an established process to manage and protect resident finances. Interviews with residents and family/whānau confirmed that resident's property is respected and finances are protected. Review of staff records and discussion with staff evidenced that all staff sign a code of conduct on commencement of employment. This outlines all aspects of professional boundaries, and the employee's responsibility to consistently meet these.

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	Policies are in place to guide staff to ensure all residents give informed consent in accordance with the Code of Health and Disability Services Consumers' Rights. Staff and management confirmed their understanding of the organisational process to ensure informed consent for all residents (including Māori, who may wish to involve whānau for collective decision making); resident files reviewed evidenced that informal consent documented. Documentation regarding EPOA, and activation is on file.
Subsection 1.8: I have the right to complain The people: I feel it is easy to make a complaint. When I complain I am taken seriously and receive a timely response. Te Tiriti: Māori and whānau are at the centre of the health and disability system, as active partners in improving the system and their care and support. As service providers: We have a fair, transparent, and equitable system in place to easily receive and resolve or escalate complaints in a manner that leads to quality improvement.	FA	The complaints procedure is provided to residents and families/whānau during the resident's entry to the service. Complaint forms are located at the entrance and in visible places throughout the facility or on request from staff. Residents or family/whānau making a complaint can involve an independent support person in the process if they choose. The complaints process is underpinned by the guidelines set by the Health and Disability Commissioner and is linked to advocacy services. The Code of Health and Disability Services Consumers' Rights and complaints process is visible, and available in te reo Māori and English. A complaints register is maintained which includes all complaints, dates and actions taken. Review of the register and discussion with the facility manager/clinical services manager confirmed that there have been no internal or external complaints received since the last audit. Discussions with residents and family/whānau confirmed that they are familiar with how to make a complaint should they wish to. Information about the support resources for Māori is available to staff to assist Māori in the complaints process. Interpreters contact details are available. The facility/clinical manager acknowledged their understanding that for Māori, there is preference for face-to-face communication and to include whānau in participation.

Subsection 2.1: Governance The people: I trust the people governing the service to have the knowledge, integrity, and ability to empower the communities they serve. Te Tiriti: Honouring Te Tiriti, Māori participate in governance in partnership, experiencing meaningful inclusion on all governance bodies and having substantive input into organisational operational policies. As service providers: Our governance body is accountable for delivering a highquality service that is responsive, inclusive, and sensitive to the cultural diversity of communities we serve.	FA	Solemar is privately owned and operated. The service is certified to provide rest home, and hospital (geriatric) level care for up to 32 residents. All beds are single occupancy, bar one room certified as suitable for two residents. Two residents who were not related shared this room on day of audit, and a process for consent for this was in place. There was a total of 25 residents on the day of audit. This included three residents on a younger person with a disability (YPD) contract receiving rest home care. One of the residents on a YPD contract was receiving respite care. There were 22 residents receiving hospital level of care; all were under the age-related residential care contract (ARRC). The service has an established organisational structure. The owner/director is the governing body for Solemar. The owner/director ensures compliance with legislative, contractual and regulatory requirements. The facility is managed by an experienced registered nurse, who holds a dual role of facility and clinical manager and provides clinical governance input. They have been in the current role since 2022. The documented aim of the service is to promote sustainable provision of quality aged care and associated services. The vision and values are reviewed annually. The owner/director receives progress updates on various topics, including staff and resident incidents, benchmarking, complaints, human resource matters, and escalated complaints. The quality and business plan reflects links with Māori and aligns with the Ministry of Health strategies. The service has identified external and internal risks and opportunities that include addressing possible inequities, and how this will be achieved. The clinical governance is the responsibility of the facility/clinical manager. Interviews and review of documentation evidenced structure in place is appropriate to the size and complexity of the service provision. Information is disseminated out to all staff, with information shared at handover. These discussions outline current clinical focus areas and the implementation of core values within the service. Monthly reports to the governing body reflect evidence of communicating quality and risk activities.

		The provider no longer has a secure dementia unit. The corrective action required from the previous partial provisional audit is now satisfied (#2.1.6)
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	There is a quality and risk management programme documented. The quality and risk management systems include performance monitoring through internal audits and through collection of clinical indicator data. The facility/clinical services manager leads and implements the quality programme. The programme involves all staff, with every staff member expected to be active in implementing a quality approach when at work and participating in the quality programme. The service is implementing the organisation's internal audit programme that includes all aspects of clinical care. Relevant corrective actions are developed and implemented to address any shortfalls. The previous shortfall from the certification audit (2.2.4) has been addressed. Progress against quality outcomes is evaluated. Reports are completed for each incident or accident, with immediate action noted, and any follow up actions(s) required, evidenced in four accident/incident forms reviewed (behaviour, unwitnessed falls, and skin tears). Each event involving a resident reflected a clinical assessment and follow up by the facility/clinical services manager, or a registered nurse. Opportunities to minimise future risks are identified by the facility/clinical services manager, or registered nurses. Relatives are informed following incidents. The facility/clinical services manager collates all the data and completes a monthly and annual analysis of results. This information is captured within the reporting tool sent to the governance body. Results are discussed in staff meetings, with meeting minutes displayed on staff noticeboards. Bi-monthly staff meetings provide an avenue for discussions in relation to quality data; health and safety; infection prevention; and complaints received (if any). Discussion with the facility/clinical services manager and review of documentation evidenced that the provider uses the plan, do, study, act (PDSA) framework to guide staff to implement and evaluate improvements made to service delivery. The outcomes of which are shared within the staff meetings. Meeting minutes sighted evidenced that staff meetings are occurring as scheduled. However, the schedule

		for resident meetings requires improvement. The 2025 resident and family/whānau satisfaction survey results were reviewed. The answers have not yet been analysed or shared with staff, residents and family/whānau. The number of respondents was low, despite the efforts of staff to ensure a satisfactory response rate. The previous shortfall (2.2.2) has been partially met. A health and safety system is in place, with identified health and safety goals. Health and safety is included in the staff meetings, with the business manager (admin support) undertaking the role of health and safety officer. They were unable to be interviewed on day of audit, so the owner/director advised how this role is facilitated on a day-to-day basis. Staff are kept informed on health and safety issues through the handover process and staff meetings. Hazard identification forms are completed, and up-to-date register was reviewed. Discussion with the facility/ clinical services manager evidenced their awareness of their requirement to notify relevant authorities in relation to essential notifications. Confirmation was provided that Section 31 notifications were completed, and notifications have been made to the Health Quality Safety Commission (HQSC) as required. The information pertaining to outbreaks in 2024-2025 were reviewed and confirmed that the outbreaks were appropriately managed, and notifications completed to the Public Health authorities.
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 documented and implemented process for determining staffing levels and skill mixes to provide culturally and clinically safe care, 24 hours a day, seven days a week. Rosters implement the staffing rationale. The facility/clinical services manager works 40 hours a week Monday to Saturday and is available on call 24/7. The facility/clinical manager, registered nurses, and senior caregivers maintain first aid certificates, so there is always a first aider on site. Review of rosters, discussion with the facility/clinical manager, care staff, residents and family/whānau confirmed that registered nurses are rostered 24/7. The owner/director confirmed they are about to recruit a further two registered nurses once pre-employment documentation has been completed. Any planned or unplanned leave was noted to be consistently covered.

		Separate cleaning staff are rostered. The laundry duties are performed by care staff working the night shift. Staff on duty on the days of the audit were visible. Residents and family/whānau gave a mixed response regarding the timeliness of response time for call bells to be responded to once activated. Staff interviewed stated that the staffing levels are adequate. They advised that the facility/clinical manager is supportive. Residents and family/whānau members interviewed reported that they believe that staff levels were adequate. The previous training plan for 2024 could not be located at the time of the audit. Training at time of audit was delivered on an ad hoc basis. There is a hard copy attendance register for each training session that has been delivered that evidenced that attendee numbers are consistently low. Educational courses offered include in-services, online, and competency questionnaires. Interview with the facility/clinical manager and review of documentation confirmed that basic training is delivered; however, an education programme appropriate for all staff to meet the residents' needs could not be located. All registered nurses have current medication competencies. All caregivers are encouraged to complete New Zealand Qualification Authority (NZQA) qualifications. There are five caregivers who have achieved level three and above, and one who has completed level two NZQA qualifications. One internationally qualified nurse is going through their registration process. Five caregivers have completed their dementia care (LCP) level four qualifications. The facility/clinical services manager and registered nurses are supported to maintain their professional competency. There are implemented competencies for registered nurses related to specialised procedures and treatments, medication, controlled drugs, manual handling, and emergencies. At the time of audit, there was one registered nurse who has completed interRAI training (facility/clinical services manager).
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.	FA	Five staff records reviewed included evidence of completed orientation, training, competencies, and professional qualifications on record where required. There are job descriptions in place for all positions that include outcomes, accountability, responsibilities, authority, and functions to be achieved in each position. A register of practising certificates is

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.		maintained for all health professionals. The service has a role-specific orientation programme in place that provides new staff with relevant information for safe work practice and includes buddying when first employed. Competencies are completed at orientation. The service demonstrates that the orientation programme supports registered nurses and caregivers to provide a culturally safe environment for Māori. Staff interviewed confirmed the orientation programme was adequate to familiarise themselves with their role, the facility, and the service. Review of staff records, discussion with the facility/clinical manager, review of the staff appraisal schedule, and discussion with staff evidenced that all staff who have been employed for a year or more, have a current performance appraisal on record.
Subsection 3.2: My pathway to wellbeing The people: I work together with my service providers so they know what matters to me, and we can decide what best supports my wellbeing. Te Tiriti: Service providers work in partnership with Māori and whānau, and support their aspirations, mana motuhake, and whānau rangatiratanga. As service providers: We work in partnership with people and whānau to support wellbeing.	PA Moderate	Five resident records were reviewed: one rest home and four hospital. The facility/clinical services manager and registered nurses are responsible for all resident's assessments, care planning and evaluation of care; however, not all initial assessments and long-term care plans were completed for residents, detailing needs, and preferences. Information obtained from the interRAI assessments was not always transferred to the individualised electronic long-term care plans (LTCPs). All LTCP and interRAI sampled had been completed within three weeks of the residents' admission to the facility. Documented interventions and early warning signs (EWS) were not always documented with sufficient information to meet the residents' assessed needs, and provided sufficient guidance to care staff in the delivery of care. The activity assessments include a cultural assessment, which gathers information about cultural needs, values, and beliefs. Information from these assessments is used to develop the resident's individual activity care plan. Short-term care plans are developed for acute problems, for example infections, wounds, and weight loss. Resident care is evaluated on each shift and reported at handover and in the progress notes. If any change is noted, it is reported to the registered nurse. Not all LTCPs are formally evaluated every six months in conjunction with the interRAI re-assessments, and when there is a change in the resident's condition.

		Long-term care plans are documented by a registered nurse and include the degree of achievement towards meeting the desired goals and outcomes. Residents interviewed confirmed assessments are completed according to their needs and in the privacy of their bedrooms. There was evidence of family/whānau involvement in care planning and documented ongoing communication of health status updates. Family/whānau interviews and resident records evidenced that family/whānau are informed where there is a change in health status. The initial medical assessment is undertaken by the general practitioner within the required timeframe following admission. Residents have ongoing reviews by the general practitioner within required timeframes, and when their health status changes. There is one general practitioner who holds weekly clinics and as required. Medical documentation and records reviewed were current. When interviewed, the general practitioner was complimentary regarding the standard of care. After-hours care is provided by the contracted medical practice, ambulance service and public hospital if required. A podiatrist visits regularly and a dietitian, speech language therapist, palliative care, wound care nurse specialist, and medical specialists are available as required through Health New Zealand. An adequate supply of wound care products was available at the facility. A review of the wound care plans evidenced that wounds were assessed in a timely manner and reviewed at appropriate intervals. Photos were taken when this was required. Where wounds require additional specialist input, a wound nurse specialist is consulted. At the time of audit there was one stage IV pressure injury. A review of the wound register evidenced this had been reported, measured, photographed, dressed as per the wound care plan, and evaluated. The remainder of wounds on the register were minor in nature, and all had been managed as per the STCP. The progress notes are recorded and maintained in the integrated records. Monthly observations such as weight and blood pressure were completed. Neurological observations are recorded following un-witnessed falls as per policy. A range of monitoring charts are available for the care staff to utilise. These include monthly blood pressure and weight monitoring, bowel records, behaviour, and repositioning charts.

		Staff interviews confirmed they are familiar with the needs of all residents in the facility, and that they have access to the supplies and products they require to meet those needs. Staff report they receive a written and verbal handover at the beginning of each shift.
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.	FA	There are policies available for safe medicine management that meet legislative requirements. All staff who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided as part of the competency process. The facility manager/clinical services manager has completed syringe driver training. Staff were observed to be safely administering medications. The registered nurse interviewed could describe their role regarding medication administration. All medications are checked on delivery against the medication chart, and any discrepancies are fed back to the supplying pharmacy. Medications were appropriately stored in locked cupboards in the medication room. The medication fridge and medication room temperatures are monitored, and all stored medications are checked weekly. Eyedrops are dated on opening. Ten medication charts were reviewed. Each chart sampled had photo identification and allergy status identified. Indications were used for (PRN) medications, and the effectiveness of PRN medication was consistently documented in the electronic medication system and progress notes. No vaccines are kept on site. There are no standing orders in use. No residents were self-administrating medications at time of audit; however, there were policy and procedure in place to guide staff in the event this changed. There was documented evidence in the clinical files that residents and relatives are updated around medication changes, including the reason for changing medications and side effects. When medication related incidents occurred, these were investigated and followed up.
Subsection 3.5: Nutrition to support wellbeing The people: Service providers meet my nutritional needs and consider my food preferences.	FA	Food preferences and cultural preferences are encompassed into the menu. The kitchen receives resident dietary information and is notified of any dietary changes for residents. Dislikes and special dietary requirements are accommodated, including food allergies. There is a

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.		verified food control plan current to August 2026. The residents and family/whānau interviewed gave mixed reviews regarding the standard of the meals served.
Subsection 3.6: Transition, transfer, and discharge The people: I work together with my service provider so they know what matters to me, and we can decide what best supports my wellbeing when I leave the service. Te Tiriti: Service providers advocate for Māori to ensure they and whānau receive the necessary support during their transition, transfer, and discharge. As service providers: We ensure the people using our service experience consistency and continuity when leaving our services. We work alongside each person and whānau to provide and coordinate a supported transition of care or support.	FA	There were documented policies and procedures to ensure discharging or transferring residents have a documented transition, transfer, or discharge plan, which includes current needs, and risk mitigation. Planned discharges or transfers were coordinated in collaboration with the resident, family/whānau and other service providers to ensure continuity of care. Evidence of residents who have been referred to other specialist services, such as wound care nurse specialists, were sighted in the files reviewed.
Subsection 4.1: The facility The people: I feel the environment is designed in a way that is safe and is sensitive to my needs. I am able to enter, exit, and move around the environment freely and safely. Te Tiriti: The environment and setting are designed to be Māori-centred and culturally safe for Māori and whānau. As service providers: Our physical environment is safe, well maintained, tidy, and comfortable and accessible, and the people we deliver services to can move independently and freely throughout. The physical environment optimises people's sense of belonging, independence, interaction, and function.	PA Low	The building has a current warrant of fitness that expires on 31 March 2026. The physical environment supports the independence of the residents; however, showed signs of wear and tear throughout all areas at time of audit. The floors and fixtures in two bathrooms need repair. Corridors have safety rails and promote safe mobility with the use of mobility aids. Residents were noted moving freely around the facility and bedrooms. There are lounges for communal gatherings and activities at the facility. Quiet spaces for residents and their visitors are available inside and externally around the decked areas. Residents are encouraged to personalise their bedrooms, with personal cultural and spiritual belongings, as viewed on day of audit. The planned maintenance schedule includes testing and tagging of electrical equipment, and this has been completed as scheduled in July 2025, and calibration and testing of medical equipment last completed August 2025.

		Hot water temperatures were within safe recommended ranges of below 45 degrees Celsius in residents' rooms. The provider no longer has a secure dementia unit. The whole facility is now unsecure. The corrective action identified at the previous partial provisional audit is now satisfied (criterion 4.1.1). Discussion with the facility/clinical manager and staff interviewed confirmed the practice of locking resident bedroom doors and denying them access, is no longer occurring. The corrective action identified at the previous partial provisional audit has been addressed (4.1.2).
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 provider has a Fire and Emergency New Zealand approved fire evacuation plan. Email (sited) from fire service confirms approval. The previous partial provisional shortfall has been addressed.
Subsection 5.2: The infection prevention programme and implementation The people: I trust my provider is committed to implementing policies, systems, and processes to manage my risk of infection. Te Tiriti: The infection prevention programme is culturally safe. Communication about the programme is easy to access and navigate and messages are clear and relevant. As service providers: We develop and implement an infection prevention programme that is appropriate to the needs, size, and scope of our services.	FA	There is infection prevention, and antimicrobial policies and procedures that includes the pandemic plan in place. The programme is linked to the quality improvement programme and is approved by the owner/director. The infection prevention policies were developed with input from infection prevention specialists, and these comply with relevant legislation and accepted best practice. The infection prevention programme evidenced this is reviewed annually. The facility/clinical services manager takes overall responsibility for the implementation of the infection prevention programme. Links in place with the public hospital and through Public Health ensure expert advice and guidance is accessible for staff on the management of infection prevention issues and the completion of audits. Staff interviews confirmed that infections are managed appropriately, reflecting adherence to established protocols.

		A review of staff training records evidenced that staff mandatory infection prevention related training is yet to be included in the education plan (Link 2.3.4). Education sessions that had been delivered had low numbers of attendees, and as part of the mandatory training schedule (Link 2.3.4). However, staff interviewed were aware of the principles of hand hygiene and the need to advise residents to remain in their rooms if they are unwell.
Subsection 5.4: Surveillance of health care-associated infection (HAI) The people: My health and progress are monitored as part of the surveillance programme. Te Tiriti: Surveillance is culturally safe and monitored by ethnicity. As service providers: We carry out surveillance of HAIs and multi-drug-resistant organisms in accordance with national and regional surveillance programmes, agreed objectives, priorities, and methods specified in the infection prevention programme, and with an equity focus.	FA	The infection surveillance programme is tailored to the facility's size and service complexity, with monitoring and management of infections. 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 electronic infection register and detailed in a monthly infection summary, where infections, including specific organisms are reviewed. Subsequently action plans are formulated and executed, which is also analysed monthly and annually for trend identification. Staff interview and review of documentation evidenced that infection prevention data captures ethnicity information. The previous shortfall (5.4.3) has been addressed. The service receives regular notifications from Health New Zealand. The last Covid-19 outbreak was July 2025. Review of documentation, discussion with the facility manager/clinical services manager, and staff confirmed this was managed appropriately and reported.
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	Maintaining a restraint-free environment is the aim of the service. Policies and procedures are in place, and the facility/clinical manager is in the process of updating these to reflect Nga Paerewa 2021. The designated restraint coordinator is a registered nurse (facility/clinical manager), who confirmed that the service is committed to a restraint-free environment. The service has effective strategies in place to maintain their no restraint stance, which includes care planning. No residents were using any form of physical restraint, and there has been no usage of restraint for an extended period. Restraint minimisation training is occurring; however, is

		yet to be placed on the training schedule (Link 2.3.4).

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.3.1 My service provider shall know and understand my rights and ensure that I am informed of my rights.	PA Low	Information pertaining to residents’ rights was displayed at the front of the facility in English and te reo Māori; however, discussion with the owner/director, staff, residents and family/whānau evidenced that the process in place regarding sharing of information with residents regarding their rights requires improvement.	i). There was no evidence residents and family/whānau were provided with information around the Code on admission. ii). Residents and family/whānau were not familiar with the Code.	i).& ii). Ensure residents and their family/whānau are provided information on admission regarding their rights and discussion is ongoing. 60 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	Staff meetings are held according to schedule and provides an avenue for quality data to be shared with staff, overall data including infection control, health and safety, internal audit results and associated corrective actions are evidenced as being discussed. The service has re-established resident,	i). There was no evidence that results from resident, family/whānau and staff surveys is analysed and corrective action plans implemented for areas that receive suboptimal results. ii). There was no evidence that all survey results are shared	i). Ensure information received from resident, family/whānau and staff surveys is analysed and corrective action plans formulated for areas that receive suboptimal results. ii). Ensure all results are

		family/whānau and staff satisfaction surveys; however, review of documentation and discussion with staff evidenced the appropriate use of this information received requires improvement. There was no evidence the results have been shared with residents and family/whānau. Resident and family/whānau meetings have recommenced; however, the schedule is inconsistently followed.	appropriately with residents, family/whānau and staff. iii). The provider is yet to implement a system that ensures all resident and family/whānau meetings occur as per schedule.	shared with residents, family/whānau and staff. iii). Ensure a system is implemented that sees all resident and family/whānau meetings occur as scheduled. 60 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	Discussion with the facility/clinical manager, staff and review of staff training records evidenced that staff training is occurring; however, the implementation of all the required staff training requires improvement. The previous education plan for 2024 could not be located, and the current plan for 2025/ 2026 was not available. The training records that were available evidenced a very low attendance.	i). A staff training schedule for the 2025-2026 period to include mandatory and annual education appropriate to meet residents care needs was not available on the day of the audit. ii). Attendance for the education sessions that had been was low.	i). & ii). Ensure a staff training schedule is evidenced, implemented and staff attend all training that is required for their respective roles and responsibilities. 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;	PA Moderate	The facility/clinical manager and registered nurses are responsible for development of al care and support plans. Resident records reviewed evidenced that residents and family/whānau are involved in the development and review of resident care plans. Residents were appropriately referred to other health professionals where required. Care plan Interventions were not always	i). One resident on respite care who was diabetic had no interventions to guide staff in the management of hyperglycaemia or hypoglycaemia. ii). One resident on respite care who identified as Māori did not have any information to guide staff to meet their cultural needs. iii). One hospital level resident	i). – vi). Ensure all resident care plans are completed with sufficient information to guide all care staff to meet all residents' assessed needs. 60 days

(c) Comprehensive assessment includes consideration of people's lived experience; (d) Cultural needs, values, and beliefs are considered; (e) Cultural assessments are completed by culturally competent workers and are accessible in all settings and circumstances. This includes traditional healing practitioners as well as rākau rongoā, mirimiri, and karakia; (f) Strengths, goals, and aspirations are described and align with people's values and beliefs. The support required to achieve these is clearly documented and communicated; (g) Early warning signs and risks that may adversely affect a person's wellbeing are recorded, with a focus on prevention or escalation for appropriate intervention; (h) People's care or support plan identifies wider service integration as required.		documented to meet resident assessed needs.	had mood triggered within their interRAI assessment and had advised staff they were feeling depressed; however, there was no documented interventions to guide care staff to recognise their low mood and take appropriate actions. iv). One hospital level resident was assessed as a falls risk, but interventions to guide staff in falls prevention were inadequate. v). Three of five hospital residents did not have goals and aspirations clearly documented, and what was documented, did not align with the residents' values and beliefs. vi). One hospital level resident who had English as their second language, did not have sufficient information to guide care staff in their required cultural needs.	
Criterion 4.1.1 Buildings, plant, and equipment shall be fit for purpose, and comply with legislation relevant to the health and disability service	PA Low	The buildings' plant and equipment is fit for purpose and complies with legislation relevant to the health and disability services being provided. The environment is inclusive of people's cultures and supports cultural practices.	i)The lino in two bathrooms has worn through and water is seeping underneath. ii) The shower head in one bathroom falls off the wall when in use. In the same bathroom, the	i). & ii). Ensure all buildings' plant and equipment is fit for purpose and complies with legislation relevant to the health and disability

being provided. The environment is inclusive of peoples' cultures and supports cultural practices.		However, observation and discussion with residents evidenced that there are areas throughout two of the bathrooms that require maintenance and repair.	call bell cannot be accessed by the residents when showering independently.	services being provided. 60 days

Specific results for criterion where a continuous improvement has been recorded

As well as whole subsections, individual criterion within a subsection can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant subsection by looking at the code. For example, Criterion 1.1.1 relates to subsection 1.1: Pae ora healthy futures in Section 1: Our rights.

If, instead of a table, these is a message “no data to display” then no continuous improvements were recorded as part of this audit.

No data to display

End of the report.