Ohope Healthcare Limited - Ohope Beach Care

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 The DAA Group Limited, 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: Ohope Healthcare Limited

Premises audited: Ohope Beach Care

Services audited: Rest home care (excluding dementia care); Dementia care

Dates of audit: Start date: 2 December 2025 End date: 3 December 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: 36

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

Ōhope Beach Care is privately owned and operated by Ōhope Healthcare Limited. The facility is located in Ōhope Beach, Whakatāne, and provides rest home and secure dementia care services for up to 36 residents.

This surveillance audit process included review of policies and procedures, review of resident and staff files, observations, and interviews with residents, whānau, the owner of the facility, the manager, and staff.

During the previous (provisional) audit, improvements were identified for 21 criteria related to the quality system and essential notification requirements, staffing and staff management, education and competency management, the environment, the activity plans for the secure dementia unit, the availability of first aid qualified staff, civil defence preparedness, infection control, and in the restraint process.

Of the 21 criteria, 13 have since been addressed. Progress has been made in areas including staff education and competency assessment, reference checking and job descriptions, 24-hour care planning in the secure dementia care unit, first aid certification, infection prevention and control practices, and restraint management.

Eight previous requirements remain in progress. These relate to education, the quality management system, essential notification requirements, staff management, the physical environment of the secure dementia care unit, and civil defence preparedness.

The current (surveillance) audit identified that eight further improvements are required. These relate to additional areas including quality evaluation, completion of adverse event reports, availability of registered nurses, monitoring of practising certification, staff orientation documentation, care planning, and general practitioner oversight.

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.

Ōhope Beach Care provided an environment that supported residents' rights. There was a health plan in place that encapsulates care specifically directed at Māori. There were residents and staff in the service at the time of audit who identified as Māori. Māori residents in the service confirmed they had been provided with equitable and effective services based on Te Tiriti o Waitangi and the principles of mana motuhake (self-determination). Cultural assessment support was in place to inform the cultural care plan.

There were no residents who align with Pacific communities at Ōhope Beach Care at the time of the audit. Systems and processes were in place to enable Pacific peoples to be provided with services that recognise their worldviews in a culturally safe manner.

Residents and their whānau had been informed of their rights according to the Code of Health and Disability Services Consumers' Rights (the Code), and these had been upheld. Personal identity, independence, privacy, and dignity were respected and supported. Staff demonstrated an understanding of residents' rights and obligations. Residents were safe from abuse.

Whānau and legal representatives were involved in decision-making that complies with the law. Advance directives were followed wherever possible.

Complaints were resolved promptly and effectively in collaboration with all parties involved. There were processes in place to ensure that the complaints process works equitably for Māori. Complaints were documented, with corrective actions in place where these were required.

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 owner of the service assumed accountability for delivering quality services. This included ensuring compliance with legislative and contractual requirements, supporting quality and risk management systems, and reducing barriers to improve outcomes for Māori, Pacific peoples, and tāngata whaikaha (people with disabilities).

Planning ensured the purpose, values, direction, scope, and goals for the organisation were defined.

A clinical governance structure was in place. Quality and risk policies and procedures were focused on improving service delivery and care using a risk-based approach.

Staff employed had skills, attitudes, qualifications and experience relevant to the service, including residents in the secure dementia care service. A systematic approach to identify and deliver ongoing learning and competencies supported safe, equitable service delivery.

Professional qualifications were validated prior to employment. Staff reported that they felt well supported through the induction and orientation process.

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.

When people entered the service, a person-centred and whānau-centred approach was adopted. Relevant information was provided to the potential resident and whānau.

Care plans were individualised. Files reviewed demonstrated that care plans were evaluated every six months.

Residents were supported to maintain and develop their interests and participate in meaningful community and social activities suitable to their age and stage of life.

Medicines were safely managed and administered by staff who had been assessed as competent to do so.

The food service was safely managed and met the nutritional needs of the residents, with specific cultural needs catered for.

Residents are referred or transferred to other health services as required.

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 facility was clean and well maintained. There was a current building warrant of fitness, and this was displayed. Electrical and biomedical equipment had been checked and assessed as required. Hot water safety checks were conducted. Some civil defence supplies were kept on site.

External areas in the rest home area of the service were accessible, safe, provided shade and seating, and met the needs of people with disabilities. External areas in the secure dementia care service had seating and shade available.

There have been no further changes to the building or services since the previous (provisional) audit.

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

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

The facility owner ensured the safety of residents and staff through a planned infection prevention (IP) and antimicrobial stewardship (AMS) programme that was appropriate to the size and complexity of the service. An experienced and trained infection control resource nurse leads the programme.

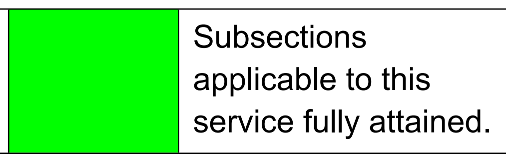
The infection control resource nurse is involved in procurement processes and any facility changes.

Staff demonstrated good principles and practice around infection control. Staff, residents and whānau were familiar with the pandemic/infectious diseases response plan.

Infection surveillance had been undertaken, with follow-up action taken as required.

There were safe and effective laundry services.

Here taratahi | Restraint and seclusion

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

The service is a restraint-free environment. This is supported by the governing body and policies and procedures. There were no residents observed to be using a restraint at the time of audit.

A comprehensive assessment, approval and monitoring process, with regular reviews, was in place should restraint use be required in the future. A suitably qualified restraint coordinator, who is a registered nurse, manages the process. Staff interviewed demonstrated a sound knowledge and understanding of providing least restrictive practices, de-escalation techniques, alternative interventions to restraint, and requirements related to restraint monitoring.

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	1	7	0	0
Criteria	0	46	0	1	15	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	Ōhope Beach Care (Ōhope) has policies, procedures, and processes to embed and enact Te Tiriti o Waitangi in all aspects of its work. A Māori health plan with an appropriate model of care had been developed with input from cultural advisors. This was in use for residents who identify as Māori. There were residents who identified as Māori in the service during the audit. They, and their whānau, confirmed that they were provided with equitable and effective services based on Te Tiriti o Waitangi and the principles of mana motuhake (self-determination), reporting that they felt culturally safe. Signage in te reo Māori was evident throughout the facility. There were staff who whakapapa to Māori communities employed by the service, and they bring their own skills and expertise and would provide advice and support if required. They have links to local iwi or other Māori communities in the area to support service integration, planning, equity approaches, and support for Māori.
Subsection 1.2: Ola manuia of Pacific peoples in Aotearoa	FA	The Pacific plan, which aligns with national strategies, was developed with input from Pacific communities and supports culturally and

The people: Pacific peoples in Aotearoa are entitled to live and enjoy good health and wellbeing. Te Tiriti: Pacific peoples acknowledge the mana whenua of Aotearoa as tuakana and commit to supporting them to achieve tino rangatiratanga. As service providers: We provide comprehensive and equitable health and disability services underpinned by Pacific worldviews and developed in collaboration with Pacific peoples for improved health outcomes.		spiritually safe practices for Pacific peoples using the service. There were no residents who aligned with Pacific communities in the service. The service has detailed policies on a range of Pacific cultures that can guide staff should a member of a Pacific community be admitted to the service.
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	Staff interviewed understood the requirements of the Code of Health and Disability Services Consumers' Rights (the Code) and were observed supporting residents in accordance with their wishes. The Code was on display at the front entrance, and brochures on the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) were accessible. Residents' information packs included information on the Code and the Advocacy Service. Residents and whānau interviewed reported being made aware of the Code and the Advocacy Service and were provided with opportunities to discuss and clarify their rights.
Subsection 1.4: I am treated with respect The People: I can be who I am when I am treated with dignity and respect. Te Tiriti: Service providers commit to Māori mana motuhake. As service providers: We provide services and support to people in a way that is inclusive and respects their identity and their experiences.	PA Moderate	Ōhope supported residents in a way that was inclusive and respected their identity and experiences. Staff were observed to maintain privacy throughout the audit. Te reo Māori and tikanga Māori were being promoted within the service. The files reviewed of residents who identified as Māori included a cultural care plan that acknowledged residents' iwi and specific cultural practices that were required to meet the residents' needs. Staff were observed speaking in te reo when addressing Māori residents. The previous audit identified that staff had not participated in training on Te Tiriti o Waitangi in the past two years. The new owners took possession of the facility in August 2025. No evidence was sighted that staff had undertaken training in Te Tiriti o Waitangi prior to or since the change in ownership. The previous corrective action remains in place (refer

		criterion 1.4.5).
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	Staff understood the service's policy on abuse and neglect, including what to do should there be any signs of such behaviour. There were no examples of discrimination, coercion, or harassment identified during the audit through staff, resident, or whānau interviews, or in documentation reviewed. Residents' property was labelled on admission. Residents and whānau reported that their property was respected, and finances protected. Staff maintained professional boundaries.
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	Residents and/or their legal representative were provided with the information necessary to make informed decisions. They felt empowered to actively participate in decision-making. With the consent of the resident, whānau were included in decision-making. Advance care planning, establishing, and documenting of enduring power of attorney (EPOA) requirements and processes for residents unable to consent were documented, as relevant, in the resident's record. Files reviewed of residents residing in the secure dementia care unit had an activated EPOA in place, and a specialist authorisation that the resident required care in a secure unit.
Subsection 1.8: I have the right to complain The people: I feel it is easy to make a complaint. When I complain I am taken seriously and receive a timely response. Te Tiriti: Māori and whānau are at the centre of the health and disability system, as active partners in improving the system and their care and support.	FA	A fair, transparent, and equitable system was in place to receive and resolve complaints that led to improvements. The process met the requirements of the Code. Residents and whānau understood their right to make a complaint and knew how to do so. Documentation sighted showed that complainants had been informed of findings following investigation. Where possible, improvements had been made as a

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.		result of the investigation. The service ensured that the process works equitably for Māori by using hui, appropriate tikanga for the person, and/or the use of te reo Māori, as applicable. One complaint had been received from the Office of the Health and Disability Commissioner (HDC) in relation a resident's care and their physical environment (no longer in the service). This was received in November 2024 and was responded to in January 2025 (following an extension permitted by the HDC); the complaint remains open. There have been no known complaints received from any other external agency.
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	The owner of the service assumes accountability for delivering a high-quality service to residents and their whānau. Compliance with all legislative, contractual, and regulatory requirements was being monitored by both the owner and the facility manager, with external professional advice obtained when required. The organisation's purpose, values, direction, scope, and goals were defined. Performance was monitored and reviewed through scheduled reporting processes. Documentation reviewed demonstrated a focus on identifying barriers to access, improving health outcomes, and promoting equity for Māori, Pacific peoples, and tāngata whaikaha. Although a commitment to the established quality and risk management system was evident, and the owner reported feeling adequately informed regarding progress and organisational risks, several processes were not consistently implemented at the facility level (refer to criteria 2.2.2, 2.2.3, 2.2.5, and 2.2.6). The facility is certified to provide care for up to 36 residents, comprising 11 rest home beds and 25 secure dementia care beds. At the time of the audit, all 36 beds were occupied. This included 11 residents receiving rest home-level care, two of whom were funded under a Long-Term Support – Chronic Health Conditions (LTS-CHC) contract, and 25 residents were residing in the secure dementia care unit. Services are being delivered under an Age-Related Residential Care (ARRC)

		services agreement with Health New Zealand – Te Whatu Ora (Te Whatu Ora).
Subsection 2.2: Quality and risk The people: I trust there are systems in place that keep me safe, are responsive, and are focused on improving my experience and outcomes of care. Te Tiriti: Service providers allocate appropriate resources to specifically address continuous quality improvement with a focus on achieving Māori health equity. As service providers: We have effective and organisation-wide governance systems in place relating to continuous quality improvement that take a risk-based approach, and these systems meet the needs of people using the services and our health care and support workers.	PA Moderate	The organisation maintains a comprehensive quality and risk management policy and procedure framework that reflects the principles of continuous quality improvement. This framework encompasses the management of incidents, accidents, and hazards, including the monitoring of clinical incidents such as falls, pressure injuries, infections, wounds, and medication errors, alongside the management of complaints and compliments, audit activities, resident and whānau feedback mechanisms, staff input, the full suite of organisational policies and procedures, and statutory and regulatory reporting. Most of these processes were being adequately managed; however, some areas are not fully managed and these need to be addressed, particularly in the areas of internal auditing and statutory and regulatory reporting (refer criteria 2.2.2 and 2.2.6). All policies reviewed were current and met the required service and contractual obligations. Residents, whānau and staff contribute to quality improvement through feedback processes, including participation in relevant meetings. The delivery of high-quality care to Māori residents was supported through the use of appropriate models of care, adherence to tikanga policies, and access to cultural support roles both within and outside the organisation. The assistant facility manager (AFM) was able to describe the processes for the identification, documentation, monitoring, review and reporting of risks, including health and safety risks, and development of mitigation strategies. However, progress against quality outcomes was not consistently evaluated, and corrective actions were not being reliably developed or implemented to address identified shortfalls. Additionally, quality data was not being effectively communicated to, or discussed with, staff (refer criterion 2.2.3 and 2.2.5). Processes were in place to ensure adverse and near-miss events could be documented in line with the National Adverse Events Reporting Policy, but these are not always completed, and whānau are not always

		informed following adverse events (refer criterion 2.2.5). The previous (provisional) audit finding regarding the completion of neurological observations following unwitnessed falls remains unresolved (refer criterion 2.2.2), despite staff in the service having completed education in neurological observation completion in 2025. Statutory and regulatory notification requirements, also identified as a finding in the previous (provisional) audit, have not been fully addressed. While the facility manager (FM) and AFM demonstrated understanding of these requirements, full compliance had not yet been achieved (refer criterion 2.2.6). There have been no police investigations reported since the previous (provisional) audit; however, a coronial referral from 2024 remains open.
Subsection 2.3: Service management The people: Skilled, caring health care and support workers listen to me, provide personalised care, and treat me as a whole person. Te Tiriti: The delivery of high-quality health care that is culturally responsive to the needs and aspirations of Māori is achieved through the use of health equity and quality improvement tools. As service providers: We ensure our day-to-day operation is managed to deliver effective person-centred and whānau-centred services.	PA Moderate	There was a documented process for determining staffing levels and skill mixes to provide culturally and clinically safe care, 24 hours a day, seven days a week (24/7). Since the sale of the facility, staff have been employed on a permanent employment basis, addressing a finding from the previous (provisional) audit. A safe rostering tool was in use that considered the physical environment. A multidisciplinary team (MDT) approach to care was in place and evidence showed that the facility adjusts caregiver and support staff levels to meet the changing needs of residents. Staff reported that there were adequate staff to complete the work allocated to them. Residents interviewed supported this, but whānau reported that staffing had reduced, and at times there were no obvious staff about the facility, and the telephones were not always answered (refer Section 3.2). A review of four weekly rosters confirmed that, apart from RN hours (refer criterion 2.3.1), adequate staff cover had been provided, with staff replaced in any unplanned absence. There was a suitably qualified FM managing the service part-time along with another care facility in the Auckland area. The FM is a registered nurse (RN). The FM is supported by an AFM who is also a RN and works full-time at the facility. A further RN works one day per week. While the leadership structure has experience and the ability to manage the complexity of the service, there are insufficient RN hours to manage clinically safe services and facility obligations (refer criteria 2.2.2, 2.2.3, 2.2.5, 2.2.6, 2.3.1, 3.2.1, 3.2.4, and 3.2.5). All staff working in the

		secure dementia care area of the facility have been signed up to a New Zealand Qualifications Authority (NZQA) education programme, also addressing a finding from the previous (provisional) audit. At least one staff member on duty had a current first aid certificate. The employment process, which included reference checking and police vetting, and validation of qualifications and annual practising certificates (APCs) for health professionals, was in place. Position descriptions defining the skills, qualifications and attributes for each role ensure that services are delivered to meet the needs of residents. There was a specific position description related to infection control and restraint activities. An orientation and continuing education programme had been planned and implemented, addressing a finding related to education in the previous (provisional) audit. Māori health information through policy and the care planning process was being used to support care delivery. Relevant competencies were assessed to support the delivery of equitable services during orientation and the ongoing education programme. Records reviewed confirmed the completion of orientation, as well as participation in the continuing education and competency assessment programme. Staff interviewed felt well supported with development opportunities and reported that access to education had increased with the new management.
Subsection 2.4: Health care and support workers The people: People providing my support have knowledge, skills, values, and attitudes that align with my needs. A diverse mix of people in adequate numbers meet my needs. Te Tiriti: Service providers actively recruit and retain a Māori health workforce and invest in building and maintaining their capacity and capability to deliver health care that meets the needs of Māori. As service providers: We have sufficient health care and support workers who are skilled and qualified to provide clinically and culturally safe, respectful, quality care and services.	PA Moderate	Human resources management policies and processes were based on good employment practice and relevant legislation. A sample of seven staff records reviewed confirmed that the organisation’s recruitment policies are being consistently implemented. This included evidence of qualifications and professional registration (where applicable). However, while monitoring of annual practising certification (APCs) was in place for registered nurses employed by the facility, this was not occurring for other health professionals involved in the service (refer criterion 2.4.3). Position descriptions for all roles were documented and sighted in the files reviewed, addressing a finding from the previous (provisional) audit. Staff orientation had been completed for staff who had been employed

		since the change of ownership; however, the orientation programme is limited and does not cover all necessary components relevant to the role (refer criterion 2.4.4). Role-specific competencies were completed for staff during the orientation phase. New staff interviewed described their orientation and 'buddy' arrangements with an experienced staff member and stated that they had felt well supported during the orientation process. Staff were encouraged to undertake a NZQA education programme in line with contractual requirements. Staff working in the secure dementia care area of the service have all been enrolled in the required education programme for the service, addressing a finding in the previous (provisional) audit. No staff have yet completed the qualification, with the exception of a diversional therapist (DT) who works alongside dementia care staff. Opportunities to discuss and review performance were noted as not occurring during the previous (provisional) audit. This has not yet been addressed, and a process to manage performance reviews is still to be implemented (refer criterion 2.4.5). A finding in the completion of reference checking on recruitment highlighted in the previous (provisional) audit has been addressed.
Subsection 3.2: My pathway to wellbeing The people: I work together with my service providers so they know what matters to me, and we can decide what best supports my wellbeing. Te Tiriti: Service providers work in partnership with Māori and whānau, and support their aspirations, mana motuhake, and whānau rangatiratanga. As service providers: We work in partnership with people and whānau to support wellbeing.	PA Moderate	The clinical records system at Ōhope was comprised of a combination of hard-copy paper files and electronic documentation. There was no clearly defined process outlining how clinical information was to be captured to ensure continuity and integration of records. Information was stored in multiple locations and was often difficult to locate. Required actions were not consistently documented. The AFM and the RN at Ōhope work with the residents and their whānau to support the residents' wellbeing. In five of the seven files reviewed, a care plan was developed by a RN following a comprehensive assessment. These care plans reflected the provider's model of care and considered the resident's lived experience, cultural needs, values, and beliefs, as well as wider service integration where

		required. Early warning signs and risks were identified, with a focus on prevention and escalation for appropriate interventions. However, the remaining two files, belonging to residents recently admitted, did not have a care plan in place to guide care. For these residents, care was provided based on verbal instructions from the AFM or RN or documentation in the progress notes. The review of seven resident files included a diverse sample of residents, encompassing residents under 65 years of age receiving care under an LTS-CHC contract, residents who identified as Māori, residents recently admitted or who had experienced a recent fall, residents who had recently required transfer to an acute facility, residents with complex behaviours requiring care in the secure dementia care unit, and residents with a wound or a number of comorbidities. Files reviewed evidenced that assessments were based on a range of clinical assessments and included resident and whānau input (as applicable). Timeframes for the initial assessment, medical or nurse practitioner assessment, initial care plan, long-term care plan, and subsequent reviews were in accordance with contractual requirements up until August 2025. Since August 2025, initial care plans had not been completed for two of three residents recently admitted (refer criterion 3.2.1), and GP reviews have not been managed as per contractual requirements (refer criterion 3.2.5). InterRAI assessments had been completed for all residents. At the time of audit, Ōhope had no access to on-site GP services and was using a virtual service. Virtual GP service cover for all residents will continue until February 2026, when a new on-site GP is expected. Currently residents are reviewed 'virtually' every three months despite there being no documentation exempting some residents from monthly GP visits (refer criterion 3.2.5). Since the previous GP left the service, management of any specific medical conditions had not been well documented in the residents' electronic files. Documentation of the findings of the virtual consultations were via email and not integrated into the residents' notes. In addition to this, care plan review had not been completed in response to changes in the residents' conditions (refer criteria 2.3.1 and 3.2.4), and residents who experienced an unwitnessed fall had not had

		neurological assessment completed or continued for the required timeframes (refer criterion 2.2.2). These are areas requiring attention. A resident with a long-standing chronic wound, recently requiring input from acute services, was noted to be having their wound managed in accordance with wound care guidelines. Input had been sought from the wound care specialist, and the wound was healing. Residents with behaviours that were complex had input from the Mental Health Services for Older People (MHSOP) team. Residents who had been at Ōhope for an extended period had documentation in the care plan identifying medical problems and nursing strategies to manage these. Staff understood and were able to support Māori and whānau to identify their own pae ora outcomes in their care plan. This was verified by sampling residents' records, and from interviews with clinical staff, people receiving services, and their whānau. Tāngata whaikaha (people with disabilities) participate in service development through discussion at meetings and through care planning activities. Examples of choices and control over service delivery were discussed with staff, tāngata whaikaha, and their whānau. Tāngata whaikaha and their whānau can independently access information.
Subsection 3.3: Individualised activities The people: I participate in what matters to me in a way that I like. Te Tiriti: Service providers support Māori community initiatives and activities that promote whanaungatanga. As service providers: We support the people using our services to maintain and develop their interests and participate in meaningful community and social activities, planned and unplanned, which are suitable for their age and stage and are satisfying to them.	FA	The activities programme at Ōhope was provided by a trained DT who supported residents to maintain and develop their interests; it was suitable for the age and stages of life for residents. A previous (provisional) audit identified that residents in the secure dementia care unit had no 24-hour care plan in place that identified the residents' previous lifestyle patterns or routines; this has been addressed. All files of residents reviewed in the secure dementia care unit had a 24-hour care plan that identified residents' previous lifestyle patterns and routines.
Subsection 3.4: My medication The people: I receive my medication and blood products in a safe	FA	The medication management policy was current and in line with the Medicines Care Guide for Residential Aged Care. A safe system for

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.		medicine management (using an electronic system) was observed on the day of audit. All staff who administer medicines had been assessed as competent to perform the function they managed. Medication reconciliation occurred. All medications sighted were within current use-by dates. Medicines were stored safely, including controlled drugs. The required stock checks had been completed. Medicines stored were within the recommended temperature range. Prescribing practices met requirements. Medicine-related allergies or sensitivities were recorded, and any adverse events responded to appropriately. Despite general GP reviews not taking place (refer criterion 3.2.5), the required three-monthly GP review was consistently recorded on the medicine chart. Standing orders were not used at Ōhope. Self-administration of medication was facilitated and managed safely.
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	The food service at Ōhope was in line with recognised nutritional guidelines for people using the services. The menu had been reviewed by a qualified dietitian within the previous two years. Recommendations made at that time had been implemented. All aspects of food management comply with current legislation and guidelines. The service operated with an approved food safety plan and registration, which expires on 28 October 2026. Food and fluids were available to residents in the secure dementia care unit at any time, day or night.
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,	FA	If Ōhope required medical services when the virtual service was unavailable, it transferred the resident to the acute facility in Whakatāne. There had been four transfers in November. Transfer or discharge from Ōhope was planned and managed safely, with coordination between services and in collaboration with the resident and their whānau. Risks and current support needs were identified and

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.		managed. Options to access other health and disability services and social/cultural supports were discussed, where appropriate. The whānau of a resident recently requiring transfer reported being kept well informed during the transfer of their relative.
Subsection 4.1: The facility The people: I feel the environment is designed in a way that is safe and is sensitive to my needs. I am able to enter, exit, and move around the environment freely and safely. Te Tiriti: The environment and setting are designed to be Māori-centred and culturally safe for Māori and whānau. As service providers: Our physical environment is safe, well maintained, tidy, and comfortable and accessible, and the people we deliver services to can move independently and freely throughout. The physical environment optimises people’s sense of belonging, independence, interaction, and function.	PA Moderate	The building had a current warrant of fitness with an expiry date of 11 October 2026. There have been no changes to the building structure since the previous (provisional) audit. The building and grounds were in reasonable repair. Plant and equipment were well maintained, and new equipment was purchased as required to promote resident independence and mobility. Records sighted confirmed annual checking of equipment, tagging and testing, and calibration of electrical devices and biomedical equipment. Testing and tagging of all ‘plug-in’ electrical equipment and biomedical checks and calibration occurred in October 2025. Hot water temperature monitoring was occurring, as confirmed in records sighted. The environment in the rest home was comfortable and accessible, promoting independence and safe mobility and minimising the risk of harm. Residents in the rest home were observed to be independently accessing the gardens, decks and external areas. There was sufficient safe and suitable seating, handrails, flat walking surfaces, and shade options provided. Smaller leisure spaces were available for residents to use. There are a number of environmental issues to be addressed in the secure dementia care unit. This was a finding in the previous (provisional) audit that has not been fully addressed (refer criterion 4.1.2). The lounge area in the secure dementia care area does not support resident comfort, with little comfortable seating available for the number of residents. This was also a finding in the previous (provisional) audit that has not been addressed (refer criterion 4.1.3). During the previous (provisional) audit, it was noted that the laundry area required attention, the area was unkempt, and the equipment

		needed for staff to manage effective infection control when sluicing soiled linen was out of reach. This has been addressed; the laundry had been tidied and was organised, and the equipment staff needed to manage effective infection control when sluicing soiled linen was readily available. Residents and whānau interviewed, however, reported that they were happy with the environment, including heating and ventilation, natural light, privacy and maintenance.
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.	PA Moderate	There have been no changes to the buildings or services since the previous (provisional) audit. One of the fire evacuation routes is through a bedroom area in the secure dementia area. The external door is locked and requires a key to open it; however, regardless of the locked door, the fire evacuation plan was approved by Fire and Emergency New Zealand (FENZ) in April 2023 following a visit to the site. The access through the room is part of the emergency fire plan. There are 13 first aid-certified staff working in the facility. On the rosters sighted, there was a first aid-certified staff member on all shifts, addressing a finding from the previous (provisional) audit. Disaster and civil defence policies direct the facility in its preparation for disasters and describe the procedures to be followed. Staff have received relevant information and training and have appropriate equipment to respond to emergency and security situations. Staff interviewed described what they would do in an emergency. An adequate amount of medical and safety supplies for up to 36 residents plus staff was being stored on site; however, not all supplies meet the National Emergency Management Agency recommendations for the region, they are not being checked on a regular schedule, and there was an insufficient amount of food and water being stored on site. This was an issue identified at the previous (provisional) audit that has not been addressed (refer criterion 4.2.7).
Subsection 5.2: The infection prevention programme and	PA Low	A finding from the previous audit identified the that the infection control resource nurse (IPRN) had no job description and had no recent

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.		training in infection control (IC) and antimicrobial stewardship (AMS). The infection prevention (IP) and AMS programme had not been reviewed annually, and staff had received no IP or AMS training in 2024 and 2025 by a person with expertise in IC. At the time, there were no staff at Ōhope who had expertise in IP or AMS to support decision-making related to procurement; this has been addressed. The AFM, who is the IPRN at Ōhope, had a job description for the role and was being supported by the FM; this addresses the finding from the previous (provisional) audit. The FM at interview stated the organisation is a member of a company that provides external advice and education on infection control. The FM has completed infection prevention and control (IPC) training at Health New Zealand/Te Whatu Ora, and the AFM has completed online training; this addresses a finding from the previous (provisional) audit. Posters on IPC were on display around the facility. Staff training and competency records for IPC were sighted; the training had been conducted by the FM who has expertise in IP, addressing a finding from the previous (provisional) audit. The IPRN was responsible for overseeing and implementing the IP programme with reporting lines to the FM. The IPRN and FM had the appropriate skills, knowledge and qualifications for the role and confirmed access to the necessary resources and support. Their advice had been sought when making decisions around procurement relevant to care delivery, design of any new building or facility changes, and policies. The infection prevention and control policies were provided by an external provider, reflect the requirements of the standard, and are based on current accepted good practice. Staff were familiar with policies through competency assessment at orientation and ongoing education and were observed to follow these correctly. The IP and AMS programme has not yet been reviewed yearly. This was a finding from the previous (provisional) audit that has not been addressed; however, it should be noted that the new provider only took ownership of Ōhope in August 2025.

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	Surveillance of health care-associated infections (HAIs) at Ōhope was appropriate to that recommended for the type of services offered and was in line with risks and priorities defined in the infection control programme. Monthly surveillance data, using standardised surveillance definitions, was being collated and analysed by the FM to identify any trends, possible causative factors, and required actions. Surveillance included ethnicity data. Day-to-day results of the surveillance programme were shared with staff at handover and with the FM, who reports to the owner; however, there was no evidence that infection quality data had been systematically analysed, trended, or used to inform quality improvement initiatives (refer criterion 2.2.3). Communication between service providers and those residents experiencing a health care-associated infection (HAI) was culturally safe.
Subsection 5.5: Environment The people: I trust health care and support workers to maintain a hygienic environment. My feedback is sought on cleanliness within the environment. Te Tiriti: Māori are assured that culturally safe and appropriate decisions are made in relation to infection prevention and environment. Communication about the environment is culturally safe and easily accessible. As service providers: We deliver services in a clean, hygienic environment that facilitates the prevention of infection and transmission of antimicrobialresistant organisms.	FA	A clean and hygienic environment supported prevention of infection and mitigation of transmission of antimicrobial-resistant organisms. Staff follow documented policies and processes for the management of waste and infectious and hazardous substances. The previous audit identified that appropriate personal protective equipment (PPE) was out of reach of staff and not being used by laundry staff when loading the washing machine with soiled clothing, and in addition to this training had not been provided. This has been addressed, appropriate PPE was being provided, it was easily available and was sighted to be in use. Staff had received training and were observed carrying out their duties safely.
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	FA	Ōhope has a philosophy and practice of no restraint and this has been endorsed by the new owner of the service. There were policies and procedures in place that meet the requirements of this standard and provide guidance on the safe use of restraints if these were to be required. The residents’ GP, EPOA or whānau would be involved in decision-making should restraint be considered. No restraint has been

practices. As service providers: We demonstrate the rationale for the use of restraint in the context of aiming for elimination.		used for over 13 years. Interviews, documents reviewed, visual inspection, and other observations during the days of audit confirmed that there were no residents using a restraint. Alternatives to restraint interventions being used were de-escalation, provision of a low stimulus environment, low beds, and sensor mats linked to the call bell system. There were processes to follow for reporting restraint to the owner if this was required. The AFM was the nominated restraint coordinator (RC) for the service, in conjunction with the FM. At the previous (provisional) audit, it was noted that the then RC had no job description and no specialist education for the role The current RC had a job description in place and had completed specialist education for the role, addressing this finding. The service continues to be committed to maintaining a restraint-free environment. At the previous (surveillance and provisional) audits, it was also noted that staff had not been trained in the least restrictive practice, safe restraint practice, alternative cultural-specific interventions, and de-escalation techniques in 2024 or 2025. This was also a corrective action required by Te Whatu Ora following a complaint made to the HDC. This has now been addressed, and staff have been trained in the least restrictive practice, safe restraint practice, alternative cultural-specific interventions, and de-escalation techniques (in October 2025).

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 1.4.5 Services shall ensure health care and support workers receive Te Tiriti o Waitangi training and that this is reflected in day-to-day service delivery.	PA Moderate	Residents who identified as Māori had a care plan that addressed their specific cultural needs. Tikanga Māori was being supported at Ōhope for residents who identified as Māori. Signage and speaking in te reo Māori were observed. Staff, however, had not received training on Te Tiriti o Waitangi within the last two years.	Staff at Ōhope had not received any training on Te Tiriti o Waitangi.	Provide evidence that staff at Ōhope receive training on Te Tiriti o Waitangi. 180 days
Criterion 2.2.2 Service providers shall develop and implement a quality management framework using a risk-based approach to improve service	PA Moderate	At the previous (provisional) audit, it was identified that neurological observations following unwitnessed falls, or incidents involving a witnessed blow to the head, were not being consistently completed. The	Neurological observations are not being completed following unwitnessed falls or a witnessed ‘blow’ to the head, as required by the service’s policy and in alignment with best practice guidelines.	Provide evidence that neurological observations are being fully completed following an unwitnessed fall or a witnessed ‘blow’ to the head in accordance with the prescribed timeframes outlined in the service’s policy and best practice standards.

delivery and care.		service's policy clearly specifies the required timeframes for conducting neurological observations over a 24-hour monitoring period. Review of a sample of accident/incident forms covering a two-month period identified five unwitnessed falls recorded in the service's resident management system. Of these five events, one had neurological observations completed, one had neurological observations partially completed (seven sets over 12 hours), and three did not have any neurological observations taken, representing non-compliance with the service's own policy requirements and best practice guidelines. An additional concern identified at the previous (provisional) audit related to the internal audit process. Internal audits were not being conducted in accordance with the established audit schedule. Only one internal audit (out of a planned 15) had been completed at the time of audit; however, this audit was incomplete and did not include the identification or implementation of corrective actions.	In addition, the internal audit schedule is not being consistently implemented, and internal audits have not been accurately completed with corrective actions identified and addressed.	Provide evidence that the annual internal audit schedule has been fully implemented and that internal audits have been accurately completed, with all sections filled in, deficits clearly identified, and corrective actions developed and implemented. 60 days

Criterion 2.2.3 Service providers shall evaluate progress against quality outcomes.	PA Moderate	Quality data was being collected by the facility and analysed by the FM, with results reported to the facility owner. However, during the audit there was no evidence that quality data, such as adverse events, infection rates, or other clinical indicators, had been systematically analysed, trended, or used to inform quality improvement initiatives. While staff interviewed reported general awareness of quality outcomes, none were able to describe current or historical quality data or demonstrate understanding of trends over the past few months. There was no documented evidence that quality data had been presented or discussed at staff/quality meetings. In addition, no visual displays or trend graphs were available within the facility to support staff engagement with quality performance measures or to demonstrate ongoing monitoring of quality outcomes.	There was no evidence available within the facility to show that quality data had been analysed, trended, and regularly reviewed, or that outcomes are clearly communicated to staff.	Provide evidence to show that quality indicators are routinely analysed and trended over time, results are shared through staff/quality meetings, with minutes demonstrating discussion and follow-up, and that visual representations (eg, graphs or dashboards) are available and updated to support staff understanding. 90 days
Criterion 2.2.5 Service providers shall follow the National Adverse Event Reporting Policy for internal and external reporting (where	PA Moderate	Processes were in place for adverse and near-miss events to be documented within the facility's resident management system, in accordance with the National Adverse Events	Adverse and near-miss events were not being consistently documented in accordance with the National Adverse Events Reporting Policy. Whānau interviews confirmed	Provide evidence to show that staff have received education on adverse event reporting and communication. Provide evidence to show that adverse event forms are being fully completed, including all required signatures and

required) to reduce preventable harm by supporting systems learnings.		Reporting Policy. Over a two-month period, a total of 24 adverse events were recorded, of which 11 were examined in detail. Of these 11 adverse events, 10 were not fully completed, with missing signatures and incomplete RN review in several instances, and seven adverse events did not include documented communication with whānau, either in the adverse event form or the corresponding progress notes. During interviews, whānau reported a lack of information regarding adverse events affecting their relatives, highlighting gaps in communication and documentation processes.	they were not always informed of adverse events affecting residents.	RN review, and provide evidence of whānau communication for all adverse events. 90 days
Criterion 2.2.6 Service providers shall understand and comply with statutory and regulatory obligations in relation to essential notification reporting.	PA Moderate	At the previous (provisional) audit, it was identified that there was insufficient understanding of statutory and regulatory reporting obligations. Since that time, the FM has changed due to a sale of the facility. Both the current FM and AFM are now able to describe statutory and regulatory reporting requirements. However, despite two Section 31 notifications being made to HealthCERT within the past three months (since the new	There was insufficient implementation of statutory and regulatory reporting processes. While the FM and AFM were able to describe reporting obligations, the facility has not consistently submitted required notifications. Additionally, the facility does not have access to the HQSC adverse events portal, which limits the ability to report incidents in a timely manner.	Provide evidence that the service has processes in place to ensure that statutory and regulatory reporting obligations are fully implemented and consistently applied. Specifically, the service must provide evidence that all required notifications to HealthCERT and the HQSC have been completed in accordance with statutory requirements, that it has ensured access to the HQSC adverse events portal, and that it maintains documentation of all notifications and evidence of timely reporting in line with regulatory obligations.

		owner assumed responsibility for the facility), no notification was submitted when a resident with dementia absconded from the secure dementia care unit. Additionally, while there has not yet been a need to report any incidents to the Health Quality & Safety Commission (HQSC), the facility does not currently have access to the adverse events portal, which is necessary to enable timely reporting should such an event occur. This indicates that, although awareness of statutory and regulatory obligations has improved, systems to ensure timely reporting in all circumstances are not yet fully implemented.		60 days
Criterion 2.3.1 Service providers shall ensure there are sufficient health care and support workers on duty at all times to provide culturally and clinically safe services.	PA Moderate	The FM is an experienced RN and aged care manager who has managed aged care facilities for the last 20 years; the last three in the Auckland facility and, for the last three months, Ōhope. The AFM advised that the FM visits for one to two days per week. The FM is supported by an AFM who is also a RN (with mental health experience) and works full-time at the facility. The AFM has two years' aged care experience and has been at Ōhope for three months, having	The shortage of RN hours is impacting completion of core clinical and safety tasks, creating a risk to resident safety and care continuity.	Provide evidence that there are sufficient RN hours available to the facility to provide clinically safe services. 90 days

		previously been employed at the Auckland facility. A further RN works one day per week, and talks are in place to increase these hours subject to availability. The clinical leadership structure has experience and the ability to manage the complexity of the service. However, even in the absence of specific requirements for RN staffing, there are insufficient RN hours to manage clinically safe services for residents alongside facility obligations. This was evident in the incompletion of resident-related activities such as care planning, effectively assessing care needs, general practitioner (GP) review, and review of adverse event reports (refer criterion 2.2.5, 3.2.1, 3.2.4, and 3.2.5).		
Criterion 2.4.3 Professional qualifications shall be validated prior to employment, including evidence of registration and scope of practice for health care and support workers.	PA Moderate	The service has a process for checking qualifications and annual practising certificates (APCs) for RNs employed in the service, at recruitment and annually. However, this system does not extend to all other health professionals involved in the service, including GPs and pharmacists. As a result, the organisation cannot be assured that all contracted or visiting	A process is not in place to ensure that all health professionals involved in the service, including GPs, pharmacists, and any contracted clinicians, have their APCs verified annually.	Provide evidence that a process is implemented to ensure that all health professionals/clinicians involved in the service have their APCs verified annually 60 days

		health professionals hold current practising certification, indicating a gap in the required verification processes.		
Criterion 2.4.4 Health care and support workers shall receive an orientation and induction programme that covers the essential components of the service provided.	PA Moderate	Staff orientation had been completed in the files of staff who had been employed since the change of ownership; however, the orientation programme is limited and does not cover all components necessary for the role. Key areas not included in the current programme include education on the Code, informed consent, EPOAs, Te Tiriti o Waitangi, and other cultural considerations.	The absence of core orientation content during the orientation process may compromise staff understanding of legal, ethical, and cultural responsibilities, increasing the potential for inconsistent or unsafe service delivery.	Develop and implement a comprehensive orientation programme that includes all required service components relevant to staff roles. This must include training on the Code, informed consent, EPOA, Te Tiriti o Waitangi, and other cultural considerations. 90 days
Criterion 2.4.5 Health care and support workers shall have the opportunity to discuss and review performance at defined intervals.	PA Moderate	Opportunities to discuss and review performance were noted as not occurring during the previous (provisional) audit and this has not yet been addressed. No staff performance appraisals have been conducted within the last year; either prior to or following the change of ownership in August 2025. It is be noted that some staff have commenced with the organisation within the last three months and are not yet due to have a performance appraisal completed	The absence of a performance review process limits the organisation's ability to monitor staff competence and support professional development, which may impact the quality and consistency of service delivery.	Provide evidence that a formal performance review process has been developed and implemented to ensure all staff receive regular, documented performance appraisals in accordance with policy and contractual requirements. The process should include clear timeframes, defined responsibilities, and documentation of performance goals, competency review, and professional development plans. Provide evidence that appraisals have been completed for all staff who are due or overdue.

				180 days
Criterion 3.2.1 Service providers shall engage with people receiving services to assess and develop their individual care or support plan in a timely manner. Whānau shall be involved when the person receiving services requests this.	PA Moderate	A review of three files of residents who had recently been admitted identified that two of the three residents had no initial care plan completed within 24 hours of admission. There were, at the time of audit, no care plans in place to guide the care these residents required. One of these residents had been at Ōhope for more than three weeks. There was an interRAI assessment completed; however, no long-term care plan was in place. One of the residents, admitted three weeks prior, had not been reviewed by the GP since admission. The third file had an initial care plan in place, and an interRAI assessment and a long-term care plan had also been completed. Ōhope is currently using a virtual GP service for its residents.	Care plans to guide the support required by residents were not consistently completed in a timely manner.	Provide evidence that all residents have an initial care plan completed in a timely manner following admission. 90 days
Criterion 3.2.4 In implementing care or support plans, service providers shall demonstrate: (a) Active involvement with the person receiving services and whānau; (b) That the provision of	PA Moderate	Five of seven files either had no care plan in place, or the care plan had not been updated to identify fully the care the resident required to meet their changing needs. This included the management plan for managing a resident's urinary catheter, potential risks and	The documentation identifying the care the resident required was not consistent with the resident's needs.	Provide evidence that the documentation identifying the care the resident requires is consistent with the resident's needs. 90 days

service is consistent with, and contributes to, meeting the person's assessed needs, goals, and aspirations. Whānau require assessment for support needs as well. This supports whānau ora and pae ora, and builds resilience, self-management, and self-advocacy among the collective; (c) That the person receives services that remove stigma and promote acceptance and inclusion; (d) That needs and risk assessments are an ongoing process and that any changes are documented.		strategies to manage the risks of residents on anticoagulant therapy, follow-up of residents identified as losing weight, and management strategies in place to manage the aggressive behaviour of a resident as per advice of MHSOP and the required strategies to monitor this. There was no documentation in the resident's file to verify that the resident had been seen by the virtual GP, including when the review occurred, the findings, or any required actions.		
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	PA Moderate	General practitioner reviews had been completed in accordance with contractual requirements up until November 2025. Since that time, two resident files reviewed had no evidence to verify the residents had been seen by a GP in the previous three months. Five resident files evidenced GP visits in September or October 2025. An interview with the AFM confirmed that residents were due for their three-monthly GP review either this month or the following month. However, none	The residents were not being reviewed by the GP within the required timeframes.	Provide evidence of documentation in the residents' files that residents are being reviewed every month, or every three months if deemed medically stable by the GP. 60 days

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.		of the residents had an exemption on file to show that the GP deemed them medically stable and able to be reviewed every three months.		
Criterion 4.1.2 The physical environment, internal and external, shall be safe and accessible, minimise risk of harm, and promote safe mobility and independence.	PA Moderate	Following a finding at the previous (provisional) audit, fencing around the two rear garden areas has been replaced with a sturdy fence; however, one of the rear gardens (the larger one) still has climbable structures in place that would allow access over the fence (the other did not have a climbable structure in place). Access to both rear gardens remains limited, residents may not access the gardens independently, and doors to the gardens are kept locked. Staff are expected to accompany residents should they wish to go outside. In addition to this, an exit space from the secure dementia care unit to the front of the building has block fencing	Climbable structures in the larger rear garden and potentially breachable fencing and gates at the front of the secure dementia care unit create a risk of residents leaving the secure areas unsupervised. Residents are unable to access the rear gardens independently.	Provide evidence that all outdoor areas are safe and secure for resident use. This includes removing or modifying climbable structures in the larger rear garden to prevent residents from accessing unsafe areas, strengthening fencing and gates at the front exit from the secure dementia care unit to prevent residents from breaching the boundary, and reviewing and updating procedures for staff supervision of residents in outdoor areas to ensure safe independent access to garden areas. 90 days

		that could be climbed, as well as a gate that could potentially be breached by residents (this has happened recently – refer criterion 2.2.6).		
Criterion 4.1.3 There shall be adequate personal space that is safe and age appropriate, and has accessible areas to meet relaxation, activity, lounge, and dining needs.	PA Moderate	This issue was identified as a finding in the previous (provisional) audit and has not been addressed. The lounge area in the secure dementia care unit serves multiple functions, including leisure, dining, and recreational activities. When all residents are present, the space becomes crowded, limiting ease of movement and comfort. There is an insufficient number of soft, comfortable chairs available for residents to use. On the day of audit, 10 comfortable chairs were available for a population of 25 residents. Those who were not using the comfortable chairs were sitting on dining chairs, which is not conducive to resident comfort, particularly for those who require extended periods of seated support. An additional smaller seating area is available; however, it was not observed to be used during either the previous (provisional) audit or this audit. The seating in this area is ‘home style three-piece suite’ type	There is an insufficient amount of soft furniture in the lounge/dining area of the secure dementia area to promote the comfort, wellbeing, and dignity of residents. Staff are not utilising other options available to them to support the comfort of residents.	Provide evidence that the lounge/dining area in the secure dementia care unit has been reconfigured or refurbished to ensure adequate, comfortable seating for all residents. The refurbishment or reconfiguration should promote resident wellbeing, comfort, and dignity, and allow ease of movement within the space. 90 days

		seating and may be too low for some residents to use effectively. Part of the space is also used for equipment storage. Staff confirmed that the area is rarely used, with only one or two residents occasionally accessing it. Overall, the environment does not fully support the comfort, wellbeing, and dignity expected for residents in a dementia care setting.		
Criterion 4.2.7 Alternative essential energy and utility sources shall be available, in the event of the main supplies failing.	PA Moderate	Equipment and resources for use during a power outage or environmental disaster were sighted and confirmed as available, for example, access to a gas (LPG) cooker, torches, and additional blankets for warmth. The previous (provisional) audit identified that there was no established system for regularly checking these supplies to ensure they are complete, in working order, and that food and water are within use-by dates. Added to this, regional guidelines recommend that emergency food be available and that four litres of water per person per day be stored for a minimum of three days. The facility currently stores food only in the kitchen area. Emergency food consisted of a	There is no established process to regularly check civil defence medical, safety, food, and water supplies to ensure they are complete, in working order, and within use-by dates. Current emergency provisions are insufficient, with stored food limited to what would be available in the kitchen on the day, a few muesli bars, and approximately 400 litres of water, which does not meet regional guidelines and does not account for staff who may be present during a civil defence emergency. This indicates that the facility is not fully prepared to meet the needs of residents and staff in the event of an emergency.	Provide evidence that a formal regime has been put in place to regularly check emergency supplies, including food, and that the availability of water in storage is sufficient to meet the recommended regional guidelines. 90 days

		few muesli bars and approximately 400 litres of water. This falls short of the recommended amount and does not account for staff who may be present at the facility during a civil emergency. There is still no process in place to check supplies on a regular basis.		
Criterion 5.2.2 Service providers shall have a clearly defined and documented IP programme that shall be: (a) Developed by those with IP expertise; (b) Approved by the governance body; (c) Linked to the quality improvement programme; and (d) Reviewed and reported on annually.	PA Low	A finding from the previous (provisional) audit noted that the IP and AMS programme had not been reviewed annually, and this has not yet been completed. The new provider took over management of the facility in August 2025. The programme in place has been developed by those with IP expertise, the programme has been approved by the facility owner, and it is linked to the quality improvement programme. Given the review has not taken place, this finding remains in place.	The IP and AMS programme has not been reviewed annually.	Provide evidence that the IP and AMS programme has been reviewed, and that there is a process in place to ensure that the programme is reviewed annually 180 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.