Thornton Park Retirement Village Limited - Thornton Park Retirement Lodge

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:	Thornton Park Retirement Village Limited
Premises audited:	Thornton Park Retirement Lodge
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 24 November 2025 End date: 25 November 2025

Proposed changes to current services (if any): This audit included verifying the service has suitable to provide residential disability-physical level care.

Total beds occupied across all premises included in the audit on the first day of the audit: 40

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six sections contained within the Ngā paerewa Health and disability services standard:

- ō tātou motika │ our rights
- hunga mahi me te hanganga │ workforce and structure
- ngā huarahi ki te oranga │ pathways to wellbeing
- te aro ki te tangata me te taiao haumaru │ person-centred and safe environment
- te kaupare pokenga me te kaitiakitanga patu huakita │ infection prevention and antimicrobial stewardship
- here taratahi │ restraint and seclusion.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the subsection in each of the sections. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All subsections applicable to this service fully attained with some subsections exceeded
	No short falls	Subsections applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some subsections applicable to this service partially attained and of low risk

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some subsections applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some subsections applicable to this service unattained and of moderate or high risk

General overview of the audit

Thornton Park Retirement Lodge (hereafter referred to as Thornton Park) is a privately owned facility certified to provide rest home level of care and hospital level care (geriatric and medical), for up to 43 residents. There were 40 residents on the day of audit.

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

This audit also included verifying the service has suitable to provide residential disability-physical level care

The manager (non-clinical) is appropriately qualified and experienced. They are supported by a clinical nurse manager and a team of experienced care staff. There are quality systems and processes documented.

Thirteen of the twenty-four shortfalls identified at the previous audit remain. These relate to the following: business planning; registered nurse shortages; staff training and competencies (noting that the service has worked to improve staff training); assessments, care planning including documentation of relevant interventions, and monitoring of care; medication management and administration (noting that allergies have now been documented and temperatures monitored); and to restraint. The service has addressed the following previous shortfalls related to the Pacific health plan; the complaints register; Te Tiriti o Waitangi training at governance level; the quality programme; essential notifications; the maintenance plan; and to the infection prevention and control programme.

This surveillance audit identified further improvements required to referral of a resident to other services and the Building Warrant of Fitness.

Ō tātou motika | Our rights

Includes 10 subsections that support an outcome where people receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of people's rights, facilitates informed choice, minimises harm, and upholds cultural and individual values and beliefs.		Subsections applicable to this service fully attained.

Thornton Park provides an environment that supports resident rights and safe care. Staff demonstrated an understanding of residents' rights and obligations. There is a documented Māori health plan and a Pacific health plan.

Residents receive services in a manner that considers their dignity, privacy, and independence. Thornton Park provides services and support to people in a way that is inclusive and respects their identity and their experiences.

An informed consent policy is implemented, and residents understood their right to make informed choices. The rights of the resident and/or their family/whānau to make a complaint is understood, respected, and upheld by the service.

Hunga mahi me te hanganga | Workforce and structure

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

Thornton Park has a documented organisational structure, mission statement, risk management framework, and quality and risk management programme. The quality programme includes regular meetings to discuss data and to ensure that any corrective actions are signed off in a timely manner. Health and safety systems are in place for hazard reporting and management of staff wellbeing.

An orientation programme is in place that provides new staff with relevant information and a buddy system to facilitate safe work practice. Staff employed for more than 12 months have an annual appraisal.

The staffing policy aligns with contractual requirements and included skill mixes. Staff, residents, and families/whānau reported that there were adequate resources to safely provide care.

Ngā huarahi ki te oranga | Pathways to wellbeing

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

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

All staff responsible for administration of medication complete education. The electronic medicine charts reviewed were reviewed at least three-monthly by the general practitioner.

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

Te aro ki te tangata me te taiao haumaru | Person-centred and safe environment

Includes two subsections that support an outcome where Health and disability services are provided in a safe environment appropriate to the age and needs of the people receiving services that facilitates independence and meets the needs of people with disabilities.		Some subsections applicable to this service partially attained and of low risk.

A Building Warrant of Fitness Report and Declaration (B-RaD) is currently in place. Clinical equipment had been serviced and calibrated as required. Electrical appliances are tested and tagged for safety. Hot water temperatures are checked regularly and maintained at a safe temperature. A preventative maintenance programme is implemented.

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

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

The infection prevention and control programme, content and detail is appropriate for the size, complexity, and degree of risk associated with Thornton Park. The infection prevention and control coordinator is a registered nurse who has received external training in the role. Ethnicity data is now collected as part of the infection prevention and control programme.

The infection prevention and control programme links to the quality and risk management system and the programme has been reviewed annually. A pandemic and outbreak plans are in place, and there is sufficient personal protective equipment available should this be required.

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.		Some subsections applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

The restraint coordinator is the clinical nurse manager (registered nurse). There are currently eight residents utilising restraints in the form of lap belts and bed rails. There are processes to document restraint assessment, interventions, monitoring, and evaluation. During orientation, staff are trained in the policy and procedures. The service considers the least restrictive practice, implements de-escalation techniques, and alternative interventions, and only use approved restraints as the last resort.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Subsection	0	12	0	2	6	0	0
Criteria	0	51	0	2	13	0	0

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

Attainment against the Ngā paerewa Health and disability services standard

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

For more information on the standard, please click here.

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

Subsection with desired outcome	Attainment Rating	Audit Evidence
Subsection 1.1: Pae ora healthy futures Te Tiriti: Māori flourish and thrive in an environment that enables good health and wellbeing. As service providers: We work collaboratively to embrace, support, and encourage a Māori worldview of health and provide high-quality, equitable, and effective services for Māori framed by Te Tiriti o Waitangi.	FA	A Māori health plan is implemented. This document acknowledges Te Tiriti o Waitangi as a founding document for New Zealand and supports mana motuhake for Māori. At the time of the audit there were residents and staff members who identified as Māori. Residents who identified as Māori confirmed on interview that the service respects and supports them in pursuing their own goals. The facility manager, clinical nurse manager, and staff interviewed (including three healthcare assistants, one registered nurse and the cook), could describe how they provide culturally safe services in relation to their roles.
Subsection 1.2: Ola manuia of Pacific peoples in Aotearoa The people: Pacific peoples in Aotearoa are entitled to live and enjoy good health and wellbeing. Te Tiriti: Pacific peoples acknowledge the mana whenua of Aotearoa as tuakana and commit to supporting them to achieve tino rangatiratanga. As service providers: We provide comprehensive and equitable health and disability services underpinned by Pacific worldviews and developed in collaboration with	FA	A Pacific health plan is in place. This document is in accordance with the Ministry of Health Pacific Plan. Criterion 1.2.3 identified as a shortfall at the previous certification is now fully attained. During the audit there were staff who identify as Pasifika. Staff receive ongoing training in cultural safety and awareness as part of the in-service education schedule, that includes recognising the world view, cultural and spiritual beliefs of Pacific people. During the audit there were no residents who identify as Pasifika.

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.	FA	Thornton Park's policies and procedures align with the requirements of the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code), and are implemented. Information related to the Code is made available to residents and their family/whānau. The Code is displayed in multiple locations in English and te reo Māori. Residents interviewed (two hospital, two rest home level and one young disabled person [YPD]), and one family/whānau (hospital level) understood their rights and expressed the service upholds their rights and the rights of their loved one.
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	Thorton Park has policies and procedures that express a zero-tolerance approach to racism, discrimination, coercion, abuse and neglect, harassment, sexual, financial, or other forms of exploitation. The policies documented also align with the Code and reflect acceptable and unacceptable behaviours. Professional boundaries are defined in the code of conduct, which staff sign on employment. Interviews with staff confirmed their understanding of professional boundaries, including the boundaries of their role and responsibilities. Professional boundaries are covered as part of orientation. Residents have property documented and signed for on entry to the service. Residents and family/whānau sign the service level agreement which includes written information on management and accountability of residents' possessions. The service implements a process to manage residents' comfort funds.
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.	FA	There is an informed consent policy in place. Six resident files reviewed included informed consent forms signed by either the resident, enduring power of attorney (EPOA) or court appointed welfare guardian. Consent forms for vaccinations were also on file where appropriate. One married couple share a room. During the audit the other double room was singly occupied. Residents and family/whānau interviewed could describe what

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.		informed consent was and their rights around choice.
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	There is a policy and procedures for complaints that are communicated to residents and family/whānau. The facility manager has overall responsibility for ensuring all complaints (verbal and written) are fully documented and investigated within timeframes determined by the Code. The facility manager maintains a complaints' register that is kept up to date. Criterion 1.8.3 is now fully attained. Concerns and complaints are discussed at relevant meetings. Since the last audit there have been no internal complaints. There are two complaints received from the Health and Disability Commissioner from 2023 that are yet to be closed. Review of the documentation relating to these show that the facility manager has forwarded the requested documentation within the timeframe required. Staff have access to information and resources to assist Māori in the complaints process. The facility manager acknowledged the understanding that for Māori there is a preference for face-to-face communication.
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	PA Moderate	Thornton Park Retirement Lodge is privately owned and operated and certified to provide hospital (geriatric and medical), and rest home levels of care for up to 43 residents. This audit included verifying the service as suitable to provide residential disability- physical level care. There are 18 dedicated rest home level beds; 20 dedicated hospital beds; and five dual purpose beds. On the day of the audit there were 40 residents; 18 at rest home level,

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.		including two with funding under young Person with a Disability (YPD); and 22 hospital, including one resident funded by the Accident Compensation Corporation (ACC), and four with DSS funding. All other residents were on the age-related residential care (ARRC) contract. The owner/director resides in Hamilton and has been involved with the business for many years, and is aware of the legislative and contractual requirements. The mission and philosophy were evidenced and reflect a resident and family/whānau centred approach to all services; however, the manager was not aware of or could not locate a documented strategic/business plan that included the service's aims, ambitions and goals. The shortfall identified at the previous audit remains. The owner and facility manager are in contact three to four times per week, and a weekly email is sent to the owner to update them on occupancy, staffing, maintenance, equipment, and some information on residents. The clinical nurse manager (CNM) completes a fortnightly report to the facility manager, which is forwarded to the owner. A new template has been developed to ensure all relevant information is communicated, including adverse events, infections, wounds, and use of restraint. The owner and facility manager liaise with the CNM (who identifies as Māori) to support outcomes to achieve equity, and to identify barriers to services for Māori, as described in the Māori health plan. Māori residents, tāngata whaikaha and family/whānau have input to improving service delivery through surveys. The facility manager, CNM and owner have completed training in Te Tiriti o Waitangi, health equity, and cultural safety. Criterion 2.1.10 is now fully attained. Cultural safety is embedded throughout the service within the quality and risk programme and evidenced by staff interviews. The CNM has oversight of clinical governance, which is appropriate to the size and complexity of the Thornton Park service. The CNM liaises with the general practitioner and Health New Zealand for clinical advice and support.
Subsection 2.2: Quality and risk The people: I trust there are systems in place that keep me	FA	The quality and risk management system includes performance monitoring through internal and external audits, and through the collection of clinical indicator data for wounds, falls, infections, incidents, restraint, complaints,

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.		medication errors, and staff injuries. Meetings are held three-monthly for all staff, and these include health safety. Meetings for healthcare assistants are held three-monthly, and meetings for registered nurses and coordinators (overseas registered nurses who have a senior healthcare assistant role) are held six-monthly. Meeting minutes include a review of previous meeting minutes and any matters arising from them. Meeting minutes include corrective actions arising from internal audits or analysis of clinical data. Clinical data is displayed on the wall for staff to see the numbers of infections, wounds and adverse events. Since the last audit, the service has implemented a new electronic system that allows them to benchmark clinical data with other aged care providers throughout New Zealand. There are regular resident and family/whānau meetings and residents and family/whānau interviewed stated they could approach the facility manager and CNM at any time to raise concerns. The last satisfaction survey results from residents and family/whānau in August 2025 showed that 90% were partially satisfied or satisfied with activities, rights, staff response, and cleanliness of home. Any recommendations were considered. A health and safety system is in place with identified health and safety goals. The facility manager maintains oversight of the health and safety system and contractor management on site. Hazard identification forms and an up-to-date hazard register were sighted. Health and safety policies are implemented and monitored monthly at the staff meetings. There are regular manual handling training sessions for staff. In the event of a staff accident or incident, a debrief process is documented on the accident/incident form. There is timely completion of investigation and reporting following staff incidents and accidents. The internal audit schedule includes health and safety, maintenance, and environmental audits. Internal audits, meetings, and collation of data are documented as taking place, with corrective actions documented where indicated to address service improvements, with evidence of progress and sign off when achieved. Criteria 2.2.2 and 2.2.3 are now fully attained. There are procedures to guide staff in managing clinical and non-clinical emergencies. Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards. A document control system is in place. New policies or changes to policy are

		communicated to staff. All resident's incidents and accidents are reported, collated and categorised. Ten incident forms were reviewed and evidenced immediate action noted, and any follow-up action(s) required. Incident and accident data is collated monthly and analysed. Results are discussed at staff meetings and shift handover. Each event involving a resident reflected a clinical assessment and follow up by a registered nurse. The adverse event reporting policy is in accordance with the National adverse event reporting policy. Discussion with the manager evidenced awareness of their requirement to notify relevant authorities in relation to essential notifications. There have been six Section 31 notifications to HealthCERT relating to residents. In addition, the CNM submits Section 31 reports on a weekly basis for registered nurse shortages (link 2.3.1). There have been no notifications to the Health Quality and Safety Commission since the last audit. There have been no outbreaks of infection since the last audit. The shortfall identified at the previous audit (2.2.6) to essential notification has been addressed.
Subsection 2.3: Service management The people: Skilled, caring health care and support workers listen to me, provide personalised care, and treat me as a whole person. Te Tiriti: The delivery of high-quality health care that is culturally responsive to the needs and aspirations of Māori is achieved through the use of health equity and quality improvement tools. As service providers: We ensure our day-to-day operation is managed to deliver effective person-centred and whānau-centred services.	PA Moderate	There is a documented staffing rationale and skill mix policy determining staffing levels and skill mix for safe service delivery. A review of the roster indicated that the number of healthcare assistants on each shift is sufficient for the acuity, layout of the facility, support with the workload, and to provide safe and timely care on all shifts. There are separate staff dedicated to activities, cleaning, laundry, cooking, and food service for seven days a week. A shortfall identified at the previous audit to RN cover remains. The CNM works 40 hours Monday to Friday and provides clinical and operational support for the care team. The CNM shares clinical on-call with the registered nurse staff 24/7. There are clear guidelines for an increase in staffing, depending on resident acuity. Interviews with staff, residents and family/whānau confirmed that staffing levels are sufficient to meet the needs of residents, despite shortages in RN cover. Staff and residents are informed when there are changes to staffing levels, as evidenced in staff interviews. Residents interviewed confirmed their care requirements are addressed in a timely manner. There is an annual training plan in place and education sessions are

		delivered as scheduled, except for restraint minimisation (link 6.1.6). A register of attendance at education sessions is completed. All staff files reviewed evidenced completion of training. Criterion 2.3.4 is now fully attained as training sessions are held as scheduled, the content of training sessions is documented, and the managers have attended training on managing an aged care facility. Assistant coordinators complete medication administration competencies and a record of staff who have completed medication competencies has been maintained. Other competencies sighted were for syringe drivers and for registered nurses. Required competencies for staff overall were not listed, and there was no policy available in relation to training and competency. The shortfall identified at the previous audit remains. Meeting minutes evidence sharing of Māori health information in relation to incidents, infections and wounds. This is an improvement from the last audit and criterion 2.3.6 is now fully attained. The service supports and encourages healthcare assistants to obtain a NZQA qualification. Six of the twenty-six healthcare assistants have completed level three NZQA (New Zealand Qualifications Authority) certificates or above. Four registered nurses (including the CNM) are interRAI trained. All registered nurses are encouraged to attend in-service training and complete additional training, including infection prevention and control, pandemic preparedness, end of life, and palliative care. Staff have completed Te Tiriti o Waitangi and cultural training, including information on Māori health outcomes, disparities, and health equity.
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	FA	A register of current annual practising certificates was sighted and included all registered nurses and the general practitioner. An orientation/induction programme provides new staff with relevant information for safe work practice. It is tailored specifically to each position and new staff are buddied with experienced staff, until they are confident and competent in their role. Five staff files reviewed (one registered nurse, two healthcare assistants, a kitchen hand, and housekeeper) evidenced implementation of the recruitment process, employment contracts, and completed orientation. All files reviewed of employees who have worked for one year or more,

clinically and culturally safe, respectful, quality care and services.		included evidence of annual performance appraisals.
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	Six electronic resident files were reviewed: four rest home, including two residents funded for YPD; and two hospital level, including one resident on an ACC contract. All files sampled identified that initial assessments and initial care plans were documented; however, these were not all completed within the required timeframes. This is a continued shortfall from the previous audit. The service uses assessment tools that include consideration of resident's lived experiences, cultural needs, values, and beliefs. Nursing care is undertaken by appropriately trained and skilled staff, including the registered nurses (RNs) and healthcare assistants. InterRAI assessments are required to be completed within 21 days; however, one hospital level resident did not have this completed within the 21-day timeframe. Long-term care plans are also required to be developed within 21 days, and to contain detailed interventions to address identified problems. However, not all were completed within the expected timeframe, and not all of the care plans included sufficient interventions and guidance for staff to safely care for the resident. Timeframes for completion of care plans and documentation of interventions are continued shortfalls from the previous audit. Resident, family/whānau and general practitioner (GP) involvement are encouraged. Long-term care plans are required to be reviewed at least six-monthly; however, not all care plans evidenced six-monthly evaluations, and not all interRAI reassessments were completed six-monthly. This is a continued shortfall from the previous audit. The care plan evaluations included the residents' degree of progress towards their agreed goals and aspirations, as well as family/whānau goals and aspirations. Strategies to maintain and promote the residents' independent wellbeing, and where appropriate early warning signs and risks that may affect a resident's wellbeing, were documented in some cases. The GP visits the service once per week and is available on call 24/7. Residents' medical admission and reviews were completed within the required timeframes. Completed medical records were sighted in all files

		sampled. Residents' files sampled identified service integration with other members of the health team. Multidisciplinary team (MDT) meetings were completed annually. The GP confirmed that medical input was sought within an appropriate timeframe, medical orders were followed, and care was person-centred. This was evidenced in the files reviewed. Information is shared between the staff at each handover, as observed on the days of audit. Interviewed staff stated that they are updated daily regarding each resident's condition. Progress notes are completed on every shift and more often if there were any changes in a resident's condition. A multidisciplinary approach is adopted to promote continuity in service delivery. The policy requires short-term care plans to be developed for short-term problems, or in the event of any significant change with appropriate interventions to guide staff; however, these were not always documented for acute needs. This is a continued shortfall from the previous audit. The short-term care plans that had been completed were reviewed weekly, or earlier if clinically indicated by the degree of risk noted during the assessment process. These were added to the long-term care plan if the condition did not resolve in three weeks. Any change in condition is reported to the clinical nurse manager (CNM) or registered nurses (RNs), as evidenced in the records sampled. Interviews verified residents and family/whānau are included and informed of all changes. There were three active wounds (skin tears) at the time of the audit. There is a wound folder of all active wounds. All wounds have individual assessments, wound management plans and evaluations forms, with photos to evidence progression towards healing. The same information is also entered on the electronic resident management system. The CNM reported that the Health New Zealand wound nurse specialists and GP have input into chronic wound management when required. A range of equipment and resources were available, suited to the levels of care provided and the residents' needs. Family/whānau and residents interviewed confirmed their involvement in the evaluation of progress and any resulting changes. The Māori health care plan in place reflects the partnership and support of residents, whānau, and extended whānau as applicable to support wellbeing. Tikanga principles are included within the Māori health care plan. Any barriers that prevent tāngata whaikaha and whānau from independently

		accessing information would be identified and strategies to manage these documented. Enduring power of attorney (EPOA)/whānau/family confirmed religious, cultural and beliefs are respected; however, one resident who identifies as Māori did not have a cultural assessment or Māori health plan completed. This is a continued shortfall from the previous audit. The staff confirmed they understood the process to support residents and family/whānau. The following monitoring charts were completed in assessing and monitoring residents: fluid balance charts; turn charts; nursing observations; wound monitoring forms; blood glucose; and restraint monitoring charts; however, not all were completed as per policy. This is a continued shortfall from the previous audit. Incident reports reviewed evidenced timely follow up by an RN.
Subsection 3.4: My medication The people: I receive my medication and blood products in a safe and timely manner. Te Tiriti: Service providers shall support and advocate for Māori to access appropriate medication and blood products. As service providers: We ensure people receive their medication and blood products in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Moderate	There is a medication management policy in place. The service uses an electronic and paper-based management system for medication prescribing, administration, review, and reconciliation. Administration records are maintained, and drug incident forms are completed in the event of any drug errors. Indications for use are noted for pro re nata (PRN) medications. Outcomes of PRN medications were not always documented for effectiveness. This is a new shortfall at this audit. Over-the-counter medications, and supplements are prescribed. There is a process for allergies to be indicated; all medication charts reviewed had this completed. This is an improvement from the previous audit. Photo identifications were current. Medications with a short shelf life in use were dated on opening and stored appropriately. Policies and procedures for residents self-administering medications are in place and this includes ensuring residents are competent, and the safe storage of medications. There was one resident self-administering medications on the day of the audit. Processes on safely managing residents who self-administer medications are in place but had not been followed. This is a new shortfall at this audit. Medication reconciliation takes place when a resident is transferred back to the service from the hospital or any external appointments. The medicines

		are checked against the prescription, and these are updated in the electronic medication management system, or on the paper file by the GP. The GP completes three-monthly reviews. Medication competencies were current, and these were completed in the last 12 months for all staff administering medicines. Medication incidents were completed in the event of a drug error, and corrective actions were acted upon. There were no expired or unused medicines, and expired medicines are returned to the pharmacy promptly. There is one medication room. Monitoring of medicine fridge and medication room temperatures is conducted regularly, and all deviations from normal had corrective actions documented. This is an improvement from the previous audit. A medication competent healthcare assistant was observed administering medications safely and correctly. Medications were stored safely and securely in the trolley, locked treatment room, and cupboards. There were no standing orders in use. The medication policy clearly outlines RN responsibilities around supporting residents, including Māori residents and their family/whānau to understand their medications.
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	Residents' nutritional requirements are assessed on admission to the service in consultation with the residents and family/whānau. The nutritional assessments identify residents' personal food preferences, allergies, intolerances, any special diets, cultural preferences, and modified texture requirements. Copies of individual dietary preferences were available in the kitchen folder. The food control plan is current to 29 November 2026.
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	PA Moderate	There is a documented process for the management of transfers and discharges. A standard transfer form from Health New Zealand is utilised when residents are required to be transferred to a public hospital or another service. Records sampled evidenced the transfer and discharge planning included risk mitigation and current residents' needs. Improvement is

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.		required in timely referral to a different level of care. The discharge plan sampled confirmed that where required, a referral to other allied health providers to ensure the safety of the resident was completed. Upon discharge, current and old notes are collated and stored in a locked cupboard in a secure area (paper-based), or in cloud storage for electronic information. If a resident's information is required by subsequent GP or service, a written request is required for the file to be transferred. Residents are supported to access or seek a referral to other health and/or disability service providers and social support or Kaupapa Māori agencies, where indicated or requested. Evidence of residents who had been referred to other specialist services, such as podiatrists, gerontology nurse specialists, and physiotherapists, was sighted in the files reviewed. EPOA/whānau/family are involved in all transfers or discharges to and from the service, and there was sufficient evidence in the residents' records to confirm this. A shortfall has been identified in relation to one resident referred to another level of care.
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 warrant of fitness is expired and a new one was not issued due to remedial work on the ventilation system needing completing. A Building Warrant of Fitness Report and Declaration (B-RaD) was issued on 25 November 2025. Residents are encouraged to personalise their bedrooms with personal, cultural and spiritual belongings, as viewed on the day of audit. There is signage throughout the facility in te reo Māori and Māori artwork displayed in all communal areas. There is a planned maintenance schedule in place that includes testing and tagging of electrical equipment, last completed on 27 June 2025 and calibration and testing of clinical equipment, last completed on 1 September 2025. During a recent power outage, a suction machine was found to be faulty, and the service has since purchased a new one. All equipment is now regularly checked as part of the maintenance schedule. Hot water temperatures have been tested and recorded in resident rooms, laundry, and kitchen monthly. The hot water temperature in resident rooms is maintained below 45 degrees Celsius. Criterion 4.1.2 is now fully attained. Sufficient equipment is available for residents. The facility is accessible for

		disabled residents. Those who have individualised equipment (such as wheelchairs), have sole use of the equipment. There are separate lounge areas for younger people to meet separate from other residents.
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	There is an approved fire evacuation scheme in place dated 28th September 2005. Regular six-monthly fire drills are completed. The last fire drill took place in June 2025 and was followed up by a staff training session on fire evacuation procedures provided by an external fire alarm contractor. The emergency management policy has been recently updated and approved by the owner following an unplanned power outage lasting for more than three hours. The emergency management policy specifies the steps for staff to take in the event of a power outage, which includes instructions for connecting the on-site generator. Staff have received training in this procedure. The emergency evacuation procedure guides staff to complete a safe and timely evacuation of the facility in case of an emergency. There are civil defence stacker boxes set up with civil defence equipment and supplies on site, and an alternative evacuation site in close proximity at Tablelands is available with its own supplies in the event of a tsunami. There is sufficient bottled water and food for each resident for a minimum of three days. All civil defence supplies are checked regularly. There is gas cooking and a gas barbecue available for alternate cooking. Fire safety and emergency management is included in staff orientation and fire safety in the ongoing education plan. A minimum of one person trained in first aid is always available. Residents' rooms, communal bathrooms and living areas all have call bells. Call bells and sensor mats when activated, light up on corridor displays in the hallways to alert staff as to who requires assistance. Call bells are regularly tested. The residents were observed to have their call bells in close proximity, and staff were observed to be responsive to call bells on the days of the audit. Residents and families/whānau interviewed confirmed that call bells are answered promptly. The facility is gated and secured. There is a security policy documented and implemented by staff. The buildings are secure at night with after-hours doorbell access, which is connected to the call bell system. There are sensor lights at the main entrance. The main entrance doors are locked

		each night at sunset and opened at sunrise.
Subsection 5.2: The infection prevention programme and implementation The people: I trust my provider is committed to implementing policies, systems, and processes to manage my risk of infection. Te Tiriti: The infection prevention programme is culturally safe. Communication about the programme is easy to access and navigate and messages are clear and relevant. As service providers: We develop and implement an infection prevention programme that is appropriate to the needs, size, and scope of our services.	FA	The infection prevention coordinator is the CNM, who is supported by two assistant coordinators. All three have completed external training on infection prevention and control in aged care facilities in 2025. Criterion 5.2.1 is now fully attained. The infection control manual outlines a comprehensive range of policies, standards and guidelines, and includes defining roles, responsibilities and oversight, training, and education of staff. Policies and procedures are now supplied by the company that manages the electronic system. Policies are available to staff. The infection prevention programme is linked to the quality system and reviewed annually, last completed in January 2025 for 2024. Criterion 5.2.2 is now fully attained. Monthly reports are generated that include infection rates, types and use of antimicrobials. These are discussed at registered nurse meetings and displayed on the wall for all staff. The infection control policy states the facility is committed to the ongoing education of staff and residents. Infection prevention and control is part of staff orientation and included in the annual training plan. There is ongoing training and education around Covid-19, and outbreaks of infection and staff are informed of any changes by noticeboards and handovers. Staff have completed handwashing and personal protective equipment competencies. Resident education occurs as part of the daily cares.
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,	FA	Infection surveillance is an integral part of the infection control programme and is described in the infection control manual. Monthly infection data is collected for all infections based on signs, symptoms, and definition of infection. Infections are entered into the infection register. Surveillance of all infections (including organisms) is entered onto a monthly infection summary. This data is monitored and analysed for trends, monthly, quarterly, and annually. Ethnicity data is included. Criterion 5.4.3 is now fully attained. The organisation benchmarks their infection data with other aged care

priorities, and methods specified in the infection prevention programme, and with an equity focus.		facilities using the same electronic system. Infection control surveillance is discussed at staff meetings and reported to the owner. Action plans are required for any infection rates of concern. Internal infection control audits are completed, with corrective actions for areas of improvement. Since the last audit there have been no outbreaks of infection. There is a policy and procedures for the management of outbreaks of infection, and sufficient stocks of personal protective equipment and supplies to manage any outbreak.
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.	PA Low	The facility is committed to becoming restraint free; while working in partnership with Māori to ensure services are mana enhancing and use least restrictive practices. The CNM on interview described the focus on working towards a restraint-free environment. There is a process of reporting to the manager and owner (governance) when restraints are required. The owner is involved in the service on a regular basis and supports the management team on eliminating any restraint use. Restraint use is part of the quality data collated. The restraint coordinator is the CNM, and a job description is documented. The restraint coordinator monitors environmental impacts on the use of restraint and implements changes that contribute to restraint minimisation. An example of this is the use of low-low beds and fall out mats. There are currently eight residents utilising a restraint (two lap belts, and eight bed rails). The restraint management policy and procedure inform the delivery of services to avoid the use of restraint. The use of alternative methods is a focus of the policy. The policy includes holistic assessment processes of the person, support plan, and information on avoiding the use of restraint. Restraint is discussed at meetings. Education on eliminating restraint is included in the orientation programme, but regular training for staff on restraint minimisation and safe practice has not been delivered since the last audit.

Subsection 6.2: Safe restraint The people: I have options that enable my freedom and ensure my care and support adapts when my needs change, and I trust that the least restrictive options are used first. Te Tiriti: Service providers work in partnership with Māori to ensure that any form of restraint is always the last resort. As service providers: We consider least restrictive practices, implement de-escalation techniques and alternative interventions, and only use approved restraint as the last resort.	PA Moderate	Restraint is only initiated and as a last resort, after consultation with the general practitioner, registered nurse and restraint coordinator, and involve the resident and/or their next of kin/representative. There is an implemented process describing the frequency and extent of monitoring restraint that relates to identified risks. The assessment process includes alternatives and identifies interventions and strategies that have been tried or implemented. There are eight residents identified on the restraint register. Restraint assessments, including associated risks, had been completed which linked to the care plan. The care plan included interventions to manage the resident's safety and dignity. Monitoring requirements are identified in restraint documentation; however, improvement is required in developing care plans to manage the safety and care of residents while in restraint, and in documenting monitoring is occurring.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 2.1.2 Governance bodies shall ensure service providers' structure, purpose, values, scope, direction, performance, and goals are clearly identified, monitored, reviewed, and evaluated at defined intervals.	PA Moderate	The service's mission, purpose and values are documented; however, a current business/ strategic plan documenting the service's strategic plans/ objectives, goals and review could not be located. The shortfall identified at the previous certification audit remains, and the risk rating has been raised from low to moderate. The timeframe to address the risk has also been shortened from 90 to 60 days.	There is no current business/strategic plan in place.	Ensure there is a current business/strategic plan in place with goals, which are monitored and reviewed at defined intervals. 60 days
Criterion 2.3.1 Service providers shall ensure there are sufficient health care and support workers on duty at	PA Moderate	The rostering and skill mix policy specifies the required staff for safe service delivery. Rosters specify what staff are on duty and the area	There is a shortage of registered nurses employed to cover shifts as per contract.	Ensure a registered nurse is on duty at all times as per contractual specifications.

all times to provide culturally and clinically safe services.		they are to work in. There is a shortfall in registered nurse cover of up to six shifts per week. There have been a total of 43 Section 31 reports lodged with HealthCERT in 2025 related to registered nurse shortages. The funder is also advised of any shortages. There are five registered nurses employed (including the CNM). One has recently resigned and one overseas registered nurse has just attained their New Zealand registration (both counted in the five RNs). The service has recruited two overseas trained registered nurses who work as assistant coordinators. They live on site and provide cover when there is no registered nurse on duty. Both are working towards New Zealand registration and help the service mitigate the risk for shifts where there is no registered nurse available. The shortfall identified at the previous certification audit remains and the risk rating has been raised from low to moderate. The timeframe to address the risk has also been shortened from 180 to 90 days.		90 days
Criterion 2.3.3 Service providers shall implement systems to determine and develop the competencies of	PA Moderate	The service has worked to address issues relating to training identified at the previous audit. This relates to ensuring that all required training sessions are held	A list of competencies for RNs and HCAs to complete is not documented and therefore not implemented.	Develop and implement a policy that specifies the competencies required for registered nurses and

health care and support workers to meet the needs of people equitably.		according to schedule; that a record of attendance is maintained; the content of the education sessions is now held on file; and the facility manager and clinical nurse manager have now attended training in relation to managing an aged care facility. Registered nurses and assistant coordinators complete medication competencies annually. RNs also complete syringe driver competencies. There is no policy that specifies the competencies required for registered nurses or healthcare assistants (HCAs) and no competencies completed by HCAs. The shortfall identified at the previous certification audit remains and the risk rating has been raised from low to moderate. The timeframe to address the risk has also been shortened from 90 to 60 days.		healthcare assistants. 90 days
Criterion 3.2.1 Service providers shall engage with people receiving services to assess and develop their individual care or support plan in a timely manner. Whānau shall be involved when the person receiving services requests this.	PA Moderate	All assessments and care plans are completed by an RN in partnership with the residents and family/whānau. There is a policy and process determining resident assessment and care plan timeframes; however, not all were completed within the required timeframes. The shortfall identified at the previous certification audit remains. While the risk rating remains at moderate, the	Two hospital residents did not have an initial assessment, initial care plan, or long-term care plan developed within the required timeframes. One hospital resident did not have an interRAI assessment completed with 21 days of entering the service. One rest home and one hospital level residents did not have their interRAI assessments reviewed six-monthly.	Ensure assessments and care plans are completed within the required timeframes. 30 days

		timeframe to address the risk has been shortened from 60 to 30 days.		
Criterion 3.2.2 Care or support plans shall be developed within service providers' model of care.	PA Moderate	The service has policy and protocols in place to ensure culturally safe care occurs; however, policy was not followed in one instance reviewed. The shortfall identified at the previous certification audit remains, and the risk rating has been raised from low to moderate. The timeframe to address the risk has also been shortened from 90 to 30 days.	One resident who identifies as Māori did not have cultural assessment or Māori health plan completed.	Ensure cultural assessments are completed and the needs of Māori are detailed in the care plan. 30 days
Criterion 3.2.3 Fundamental to the development of a care or support plan shall be that: (a) Informed choice is an underpinning principle; (b) A suitably qualified, skilled, and experienced health care or support worker undertakes the development of the care or support plan; (c) Comprehensive assessment includes consideration of people's lived experience; (d) Cultural needs, values, and beliefs are considered; (e) Cultural assessments are completed by culturally competent workers and are	PA Moderate	There is a policy and process determining resident assessment and care plan content; however, not all care plans contained sufficient interventions or content to guide staff in the safe care of residents' conditions. The shortfall identified at the previous certification audit remains. While the risk rating remains at moderate, the timeframe to address the risk has been shortened from 60 to 30 days	(i). One hospital resident's long-term care plan has not been fully documented, including no interventions for known choking risk; mobilisation; behaviours that challenge; and further interaction for known collapses, including recognition and intervention (and not for transfer to hospital). (ii). One hospital resident has no interventions for known risks, including cognitive function, and end of life. (iii). One resident who is a known wanderer has no care plan interventions or physical interventions to monitoring his movements. (iv).Two hospital and one rest home resident care plan have sections of the care plan that have not been	(i)-(iv) Ensure care plans are sufficiently detailed to guide staff in the safe care and management of resident's needs and medical conditions. 30 days

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.			completed.	
Criterion 3.2.4 In implementing care or support plans, service providers shall demonstrate: (a) Active involvement with the person receiving services and whānau; (b) That the provision of service is consistent with, and contributes to, meeting the person's assessed needs, goals, and aspirations. Whānau require assessment for support needs as well. This supports whānau ora and pae ora, and builds resilience, self-management,	PA Moderate	Policy states a requirement for neurological observations being undertaken for unwitnessed falls, or where there is suspected injury to the head. However, for six falls related incidents that were reviewed, the unwitnessed falls did not have neurological observations completed according to policy. Care plans also detail the repositioning requirements for residents at risk of a pressure injury; however, these did not occur as detailed in all cases. The shortfall identified at the previous certification audit remains. While	(i). Positioning charts were not consistently completed for two residents requiring two hourly turns. (ii). Neurological observations were not completed as per policy for six unwitnessed falls reviewed.	(i). Ensure repositioning charts are completed as per policy. (ii).Ensure neurological observations are completed as per policy. 30 days

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.		the risk rating remains at moderate, the timeframe to address the risk has been shortened from 60 to 30 days.		
Criterion 3.2.5 Planned review of a person's care or support plan shall: (a) Be undertaken at defined intervals in collaboration with the person and whānau, together with wider service providers; (b) Include the use of a range of outcome measurements; (c) Record the degree of achievement against the person's agreed goals and aspiration as well as whānau goals and aspirations; (d) Identify changes to the person's care or support plan, which are agreed collaboratively through the ongoing re-assessment and review process, and ensure changes are implemented; (e) Ensure that, where progress is different from expected, the service provider in collaboration with the person receiving services and whānau responds	PA Moderate	Care plans had not been evidenced as reviewed six-monthly in the four files reviewed of residents who had a care plan, and had been in the service longer than six months. Short-term care plans had not been used for one hospital resident who has recently returned from hospital with changed care needs.	(i). Care plans had not been evidenced as reviewed six-monthly in the four files reviewed of residents who had a care plan, and had been in the service longer than six months.(ii). Short-term care plans had not been used for one hospital resident who has recently returned from an acute hospital stay, with changed care needs.	(i). Ensure all care plans are evidenced as being evaluated at least six-monthly.(ii). Ensure short-term care plans are utilised for all short-term needs as per policy. 30 days

by initiating changes to the care or support plan.				
Criterion 3.4.1 A medication management system shall be implemented appropriate to the scope of the service.	PA Moderate	There is a management system implemented for medication prescribing, administration, review, and reconciliation. Administration records are maintained, and drug incident forms are completed in the event of any drug errors. Indications for use are noted for pro re nata (PRN) medications; however, effectiveness of PRN medication is not documented.	Staff administering PRN medications do not always document if they have been effective, including administration of morphine, senna and zopiclone.	Ensure that the effectiveness of pro re nata medications is documented. 30 days
Criterion 3.4.6 Service providers shall facilitate safe self-administration of medication where appropriate.	PA Moderate	Policies and procedures for residents self-administering medications are in place and this includes ensuring residents are competent, and the safe storage of medications. There was one resident self-administering medications on the day of the audit. Processes on safely managing residents who self-administer medications are in place, but had not been followed.	One resident self-administers their own midazolam spray. The medication chart says two hourly. The resident stated they can take it hourly. The resident does not have a competency assessment from the GP. There is no documented follow up by RNs to monitor use of self-administration of medication.	Ensure that the resident is fully aware of the dosage and timeframes they can self-administer in. Ensure that the resident has a completed assessment and competency to manage their own medications. Document evidence that RNs monitor and document self-administration of medication and competency of residents who self-administer. 30 days

Criterion 3.6.1 Service providers shall implement a process to support a safe, timely, seamless transition, transfer, or discharge.	PA Moderate	There is a documented process for the management of transfers and discharges. A standard transfer form from Health New Zealand is utilised when residents are required to be transferred to a public hospital or another service. Records sampled evidenced that residents are not always referred to alternative levels of care when needed.	One resident was found wandering; although, there is an incident form and notification documented. There has been no further action regarding referral for a different level of care, despite the service notifying HealthCERT that they are unable to manage the resident.	Ensure that residents are referred to appropriate levels of care as needed. 30 days
Criterion 4.1.1 Buildings, plant, and equipment shall be fit for purpose, and comply with legislation relevant to the health and disability service being provided. The environment is inclusive of peoples' cultures and supports cultural practices.	PA Low	A BRaD was issued as remedial work was required for the building warrant of fitness. The manager stated this work has now been completed. Electrical appliances and clinical equipment are tested, serviced and calibrated as part of the regular maintenance schedule. The environment has artwork and signage that is inclusive of the residents' cultures and cultural practices.	There is no current building warrant of fitness.	Ensure there is a current building warrant of fitness. 180 days
Criterion 6.1.6 Health care and support workers shall be trained in least restrictive practice, safe practice, the use of restraint, alternative cultural-specific interventions, and de-escalation techniques within a culture of continuous learning.	PA Low	During orientation, staff are trained in the restraint minimisation policy and procedures.	Since the last audit, there has been no education sessions delivered on restraint minimisation and safe practice.	Ensure restraint minimisation and safe practice is part of the annual education programme. 180 days

Criterion 6.2.1 The decision to approve restraint for a person receiving services shall be made: (a) As a last resort, after all other interventions or de-escalation strategies have been tried or implemented; (b) After adequate time has been given for cultural assessment; (c) Following assessment, planning, and preparation, which includes available resources able to be put in place; (d) By the most appropriate health professional; (e) When the environment is appropriate and safe.	PA Moderate	Restraint documentation reviewed included alternative strategies tried; cultural needs; impact of restraint on the resident; potential risks; and approval of the general practitioner, registered nurse, restraint coordinator and family/whānau. This is an improvement from the previous audit where assessment and identification of risks was not completed.	Three of three resident files for residents using restraint did not have a care plan in place related to use of restraint. This is a continued shortfall, and the risk remains as moderate.	Ensure care plans are in place for residents using restraint. 60 days
Criterion 6.2.2 The frequency and extent of monitoring of people during restraint shall be determined by a registered health professional and implemented according to this determination.	PA Moderate	The frequency of restraint monitoring is determined by the restraint coordinator based on the risk to the resident. Restraint monitoring requirements are detailed on the restraint form.	Restraint monitoring charts were not completed in three of the three files reviewed. This is a continued shortfall, and the risk rating has been raised to moderate.	Ensure restraint monitoring charts are completed as per the policy. 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.

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