The Whalan Lodge Trust - Whalan 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:	The Whalan Lodge Trust
Premises audited:	Whalan Lodge
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 11 December 2025 End date: 12 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: 14

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Whalan Lodge is operated by a community trust. The service provides rest level of care for up to 19 residents and on the day of the audit, there were 14 residents.

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

The manager is non-clinical and has been in the role for one year. They are supported by an administrator and a registered nurse. Residents, family/whānau and the general practitioner interviewed were complimentary of the service and care provided.

The service has addressed eleven of the 19 shortfalls identified at the previous audit related to in relation to the Trust developing relationships with Māori and Pasifika; Māori representation at Trust level; completion of cultural training by Trust members; clinical governance; collection and analysis of ethnicity data, and aspects of infection control. The service has also addressed partial provisional shortfalls related to issuing of current warrant of fitness including the new; installation of the call bell system; sign off the fire evacuation scheme; aspects of staff training; and completion of the laundry.

The following continued shortfalls from the previous audit have not yet been addressed: governance signoff of the quality and risk systems, complaint management; aspects of quality management including internal audits, satisfaction surveys, corrective actions, health and safety management, management reports to the board; availability of meeting minutes and staff appraisals.

This surveillance audit identified shortfalls related to annual review of risk management systems, maintenance schedules; staff training; staff competencies; staff orientation, staff position descriptions; and aspects of medication management including; controlled drugs, short life medications, effectiveness, staff competencies, self-administration of medication; management of stock medication and, also testing of electrical equipment.

Ō tātou motika | Our rights

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

Whalan Lodge provides an environment that supports resident rights and culturally safe care. The service is committed to supporting the Māori health strategies documented in the Māori health plan by actively recruiting and retaining suitably qualified Māori staff when available. Details relating to the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers Rights (the Code) is included in the information packs given to new or potential residents and family/whānau.

Hunga mahi me te hanganga | Workforce and structure

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

An orientation programme is in place for new staff. The facility is fully staffed. An annual education programme is documented.

Ngā huarahi ki te oranga | Pathways to wellbeing

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

The registered nurse is responsible for the assessment, development, and evaluation of care plans. Residents and family/whānau stated that they have input into their plans. Long term care plans identified interventions that were well implemented during the audit.

The facility uses an electronic medicine management system for prescribing, and for documentation of administration of medications. The general practitioner is responsible for all medication reviews with these completed as per timeframes.

The food service caters for residents' specific dietary likes and dislikes. There is a current food control plan.

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 are partially attained and of low risk.

There is a current building warrant of fitness. All medical equipment is checked and calibrated. There is a planned and reactive maintenance programme documented. Five new resident rooms, dining room refurbishment and landscaping have been completed.

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

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

The infection control programme is reviewed annually. Surveillance data is documented and discussed at staff meetings. Infections are recorded on an incident form with data collected and analysed for trends, and the information used to identify opportunities for improvements. There have been no infectious outbreaks since the last audit.

Here taratahi | Restraint and seclusion

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

The service is committed to a restraint-free service. The philosophy is supported by the manager and policies and procedures. Staff interviewed demonstrated a sound knowledge and understanding of providing the least restrictive practice, de-escalation techniques and alternative interventions to prevent the use of restraint. There was no restraint in use on the days of audit.

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	5	1	0
Criteria	0	49	0	2	11	2	0

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

Attainment against the Ngā paerewa Health and disability services standard

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

For more information on the standard, please click here.

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

Subsection with desired outcome	Attainment Rating	Audit Evidence
Subsection 1.1: Pae ora healthy futures Te Tiriti: Māori flourish and thrive in an environment that enables good health and wellbeing. As service providers: We work collaboratively to embrace, support, and encourage a Māori worldview of health and provide high-quality, equitable, and effective services for Māori framed by Te Tiriti o Waitangi.	FA	A Māori Health Plan is documented for the service. This plan acknowledges Te Tiriti o Waitangi as a founding document for New Zealand. The service currently has no residents or staff who identify as Māori. Staff undertake cultural competencies and are knowledgeable in ways to support the health and wellbeing of Māori residents and their family/whānau. Residents and family/whānau are involved in providing input into the resident's care planning, their activities, and their dietary needs. The service recognises Māori mana motuhake and this is reflected in the Māori health plan. Discussion with two board members identified services available for staff and members of the trust board to maintain involvement and engagement with Māori in the local community. Interviews with five staff (three caregivers, one cook and one registered nurse) and one manager demonstrated a knowledge of implementing the principles of Te Tiriti O Waitangi to all aspects of the service. Māori kaumātua were involved in blessing of the opening of the new wing. The previous partial attainment criteria #1.1.5 has been addressed.
Subsection 1.2: Ola manuia of Pacific peoples in Aotearoa The people: Pacific peoples in Aotearoa are entitled to live	FA	The Pacific health plan upholds the principles of Pacific people by acknowledging respectful relationships, valuing families, and providing

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.		high quality health care. On admission all residents state their ethnicity. There were no residents or staff who identify as Pasifika; however, staff stated that they could access local external expertise, support and input into resident cares to ensure that they reflected Pacific values and beliefs. They also stated that they could access expertise through Health NZ if they had questions around supporting Pasifika. The RN has linkages to Pasifika through Health New Zealand, and the service has developed a relationship with Pacific communities and healthcare providers who provide advice where required. Pasifika Trust representatives have visited the service and discussed availability of community resources and support. On interview the registered nurse and caregivers were aware of how to access resources. The previous partial attainment criteria #1.2.5 has been addressed. Interviews with five residents and three family/whānau, and documentation reviewed identified that the service uses a person-centred approach, and the manager listens to resident and family/whānau feedback to guide individual service delivery.
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 receive education in relation to the Health and Disability Commissioner's (HDC) Code of Health and Disability Consumers' Rights (the Code) at orientation and through the annual education and training programme which includes understanding the role of advocacy services. All caregivers have completed training in November 2023 around the Code (link # 2.3.4). Details relating to the Code are included in the information that is provided to new residents and their family/whānau. The registered nurse (RN) and the manager discuss aspects of the Code with residents and their family/whānau on admission. The Code is displayed in multiple locations in English and te reo Māori. Discussions relating to the Code are held as per resident request with an 'open door' policy in place that supports residents to ask the manager or registered nurse anything related to the Code. Residents and family/whānau interviewed reported that the service is upholding the residents' rights. The manager and staff interviewed (including three caregivers, the registered nurse and the cook) were able to describe care provided as per

		the Code.
Subsection 1.5: I am protected from abuse The People: I feel safe and protected from abuse. Te Tiriti: Service providers provide culturally and clinically safe services for Māori, so they feel safe and are protected from abuse. As service providers: We ensure the people using our services are safe and protected from abuse.	FA	An abuse, neglect and prevention policy is being implemented. The general practitioner (GP), staff, the manager, residents and family/whānau interviewed stated that there was no evidence of abuse or neglect. The manager and staff at Whalan Lodge ensure that there is no discrimination, with residents and staff stating that if there was, then they would feel comfortable raising this immediately with the manager. A policy that focuses on conduct is provided during the new employee's induction to the service. The staff wellness in the workplace and workplace bullying policies address the need to identify and then eliminate any discrimination, harassment, or bullying. The manager and staff stated that all are held responsible for creating a positive, inclusive and a safe working environment. The manager and staff interviewed acknowledged the impact of institutional racism on Māori wellbeing and all stated that there was no evidence of bullying or harassment. Cultural diversity is acknowledged with the activities programme facilitating cultural days to celebrate diversity including cooking of Filipino meals. The service implements a process to manage residents' comfort funds, such as sundry expenses. Professional boundaries are defined in job descriptions. Interviews with the manager, RN and caregivers confirmed their understanding of professional boundaries, including the boundaries of their role and responsibilities. Staff are required to be educated on abuse and neglect, professional boundaries, cultural safety including systemic racism and health care bias; however, on the day of audit there was no evidence of recent related training (link # 2.3.4).
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	FA	Informed consent processes were discussed with residents and family/whānau on admission. Five resident files were reviewed. Written general consents were sighted for photographs, shared rooms, release of medical information and medical cares. All had a signed admission agreement completed as part of the admission process. Residents were observed to give consent during cares on the days of audit.

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.		
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.	PA Moderate	The complaints policy is provided to residents and family/whānau on entry to the service. Access to complaint forms is located at the entrance to the facility or on request from staff or managers. The manager maintains a record of all written complaints by using a complaint register. This register is held electronically. The policy ensures that the complaints process shall work equitably for Māori with the manager recognising that face-to-face communication is preferable for Māori. Residents and family/whānau making a complaint can involve an independent support person in the process if they choose. The complaints process is linked to advocacy services. The Code is available in te reo Māori, and English. There has been one complaint since the previous audit; however, this has not been documented in accordance with policy or the Health and Disability Commission. Residents and family/whānau interviewed confirmed that they raise any concerns directly with the manager and or the registered nurse at any time. Discussions with residents and family/whānau confirmed that they were provided with information on the complaints process. Complaints are a standard agenda item at monthly staff meetings and on interview, staff had a good understanding of the complaints process. This aspect of the previous partial attainment has been addressed; however further aspects of noncompliance in #1.8.3 have been identified at this this audit.
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.	PA Moderate	Whalan Lodge is located in Kurow, Central Canterbury. The service has 19 beds for residents requiring rest home level of care. Fourteen of the 19 were occupied on the day of the audit. One resident was under an ACC respite contract, and all others were under the Age-Related Residential

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 high quality service that is responsive, inclusive, and sensitive to the cultural diversity of communities we serve.		Care (ARRC) contract. The service is governed by a community trust consisting of seven members, each with their own expertise and there are terms of reference for the Trust. The manager, the registered nurse and the administrator each provide a monthly report to the Trust; however, while the registered nurse report includes internal clinical related audit results and corrective actions the managers' report does not reflect non-clinical audit results or quality data (link # 2.2.2). The registered nurse's report includes ethnicity data for clinical indicators. There is a documented clinical governance structure in place, and the registered nurse reports they are well supported by the medical practitioner at the local medical centre. The previous partial attainment # 2.1.11 has been addressed. There is collaboration with mana whenua through Health NZ which reflects in business planning and service development that supports outcomes to achieve equity for Māori. The previous partial attainment #2.1.9 has been addressed. The manager and RN meet at least weekly to discuss any management or clinical changes or issues. A monthly reporting process from quality and risk data is entered into the electronic resident management system for monitoring incidents, adverse events, restraint use, infections, and care plan timeframes. There is a business plan 2024 that has been reviewed at the end of the year. The 2025 business plan is documented. The values, purpose and scope of the service is documented. There is a documented quality policy and quality programme; however, there no evidence in the business plan to support the Trust's sign off of the quality system. The previous partial attainment # 2.1.4 has not yet been addressed. The manager understands their responsibility in the implementation of Health and Disability Services Standard and explained their commitment to Te Tiriti obligations. The obligations to proactively help address barriers for Māori and to provide equitable health care services is documented in the quality, and risk management policy. The Māori health plan is documented, and this reflects a leadership commitment to collaborate with Māori and aligns with the Ministry of Health strategies. All members of the Trust have completed cultural training including Te Tiriti o Waitangi, health equity and cultural safety. The previous partial attainment # 2.1.10 has been addressed. The manager (non-clinical) oversees the day-to-day operations and provides leadership and commitment to the quality and risk management

		system. The manager who works 30 hours a week was appointed one year ago. The manager has a caregiving background and is supported by a part time registered nurse. The RN was appointed almost three years ago and is experienced in her role. The RN when interviewed described their role in oversight of the clinical aspects of the service. They report to the manager and the trust board.
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	Whalan Lodge has a documented quality and risk management programme. The quality and risk management systems include performance monitoring through internal audits and through the collection of data against clinical indicators. The quality management framework documents a risk-based approach to improve service delivery and care as documented in policy, the quality and risk system continued to be not fully implemented. An external consultant reviews all policies and supports the manager, the RN and staff as required. The manager provides a monthly report to the Trust; however, the report does not consistently include quality indicators including health and safety, complaints, human resource concerns or internal audit and corrective action information. There is an organisational risk management plan, a hazard register and a maintenance schedule. These are in place to help manage risk; however, the registers and preventative maintenance schedule have not been updated or reviewed since 2023. Electronic reports are completed for each incident/accident with evidence of the RN reviewing all adverse events in a timely manner and documenting opportunities to minimise risks identified. There are monthly staff meetings which provide an avenue for discussions in relation to quality goals, quality data, health and safety, infection control/pandemic strategies, complaints received (if any), and cultural compliance. The quality clinical data includes ethnicity. The previous partial attainment # 2.2.8 has been addressed. A review of 2025 confirmed that meetings had been held as scheduled. Meeting minutes evidenced discussion of internal clinical audit results and corrective actions however, the corrective actions were not always in sufficient detail to guide staff. Quality goals are not established for 2025. Meeting minutes documented were not evidenced as being available to staff who were not able to attend

		the meeting. Internal audits are evidenced as occurring as scheduled. This aspect of # 2.2.2. has been addressed; however, further aspects of non-compliance have been identified at this audit. On the day of audit, internal audits did not evidence sign off on completion for non-clinical audits and identified corrective actions were not evidenced as being closed off. There is a digital bulletin board, and the manager or RN leave messages for staff as required. This helps to keep staff updated, noting that staffing numbers are small, and staff see each other day to day as rostered. The service has not offered satisfaction surveys in 2024 or 2025 for residents and/or family/whānau to complete. The quality plan includes annual surveys as documented in the policy. Residents and family/whānau interviewed confirmed that there are ample opportunities for them to express their satisfaction or otherwise and confirmed that they felt heard. Discussions with the manager confirmed their awareness of the requirement to notify relevant authorities in relation to essential notifications including the severity assessment code (SAC) reporting to the Health Quality Safety Commission. The manager reported have been no notifications made since the previous audit. A section 31 was submitted for the appointment of the facility manager. The previous partial attainment # 2.2.6 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	The roster provides appropriate coverage for the effective delivery of care and support. Interviews with staff confirmed that the workload is manageable. Residents stated that there are sufficient staff on site and on duty. Staff and residents are informed when there are changes to staffing as evidenced in staff meeting minutes and in interviews with staff and the manager. The manager is available Monday to Friday. Staff stated that the manager and RN are on call and available if required. Staff stated that the manager and the RN attend when required. The education and training schedule includes compulsory training however has not included the Code of rights, cultural safety, emergency response, oral health, food services, nutrition, Treaty of Waitangi in 2024 or 2025. Staff complete training at monthly staff meetings and competency questionnaires at their own pace; however, there was minimal evidence

		that all caregivers had completed required training in 2024 and 2025. All staff have an individual training record and file however this has not been maintained. Staff are expected to complete competencies related to their role during the orientation process and are included in the training sessions scheduled in the education planner; however, competency evidence sighted is not current for medication, hand hygiene, cultural safety and personal protective clothing. The RN has completed interRAI training, clinical and management training through online sessions and online resources. The facility manager could not evidence training other than those provided at some staff meetings. The service supports staff who wish to complete training through New Zealand Qualification Authority (NZQA). There are nine caregivers employed at Whalan Lodge. There was one caregiver with a level 3 certificate, one with a level 2 and two caregivers were identified as senior caregivers through the number of years of experience while working in the service. Three caregivers have overseas nursing qualifications. Two caregivers have no qualifications.
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	Five staff files reviewed (the RN and four caregivers) confirmed that all have a signed contract, a current practicing for the RN and other health professionals e.g. the doctor, Job descriptions are not on file for all staff. An orientation/induction programme provides new staff with relevant information for safe work practice. Staff confirmed that orientation includes buddying when first employed. Caregivers interviewed reported that the orientation process prepared new staff for their role and could be extended if required. Non-clinical staff have a modified orientation, which covers all key requirements of their role as confirmed by the manager and registered nurse. Completion of orientation was documented for some staff; however, not all staff had an orientation on file. There is an annual performance process scheduled for all staff, however, this has not been implemented as per policy since September 2024. The previous partial attainment # 2.4.5 continues to require addressing.

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.	FA	Five resident files sampled identified that initial assessments and initial care plans were person centred, and these were completed in a timely manner. The files reviewed included a resident under an ACC respite contract. InterRAI assessments were completed within 21 days of admission. Nutritional requirements forms were updated following interRAI assessments. The resident, family/whānau, and general practitioner (GP) are encouraged to be involved in the plan of care. Each resident had a long-term plan documented with interventions that reflected identified needs. Observations during the audit confirmed that interventions were used as per individualised plans. The long-term plan is updated as changes occur. A contracted GP visits weekly and is available whenever required. The GP completes the residents' medical admission within the required timeframes (on site) and conducts medical reviews promptly within timeframes documented and at least three monthly. Completed medical records were sighted in all files sampled. The GP interviewed confirmed a high level of satisfaction with communication and stated medical input was sought in a timely, logical manner, and medical orders were followed appropriately. Residents have access to a contracted podiatrist. A private physiotherapist at the nearest town or Health NZ physiotherapist at the nearest hospital is available as required. Residents are referred to other health providers as per their needs e.g. residents were referred to counselling services for anxiety, dietician and a speech language therapist for difficulty with swallowing. The RN and caregivers reported that sufficient and appropriate information is shared between the staff at each handover. The handover is both digital and verbal. Interventions were resident focussed and provide detail to guide staff in the management of each resident`s care. A range of equipment and resources are available, suited to the level of care provided, and in accordance with the residents' needs. Family/whānau and residents interviewed confirmed their involvement in the evaluation of progress and any resulting changes. Progress notes were completed on every shift and more often if there were any changes in a resident's condition. There are no pressure injuries and three current wounds. One chronic wound is being managed by a district nurse wound specialist. There is a process to document wound

		assessments and management plans if these are identified. Monitoring charts are completed when required e.g. for documenting behaviours that challenge, weights, neurological observations following a fall or if a resident has hit their head, and blood glucose. The charts have been completed as per plans.
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 High	There are policies documented for safe medicine management that meet legislative requirements. Staff who administer medications are required to complete annual competencies; however, this was not evidenced for all staff who administer medications. Education around safe medication administration was last held in March 2024; however, records of attendance were not available on the days of audit. (link # 2.3.4). Regular medications are administered from pharmacy prepared packs. As required medication is administered from packages and bottles. The RN checks the packs against the electronic medication chart, and a record of medication reconciliation is maintained. Any discrepancies are fed back to the supplying pharmacy. Medications reviewed are stored securely in a locked cupboard or medication trolley in the nurse's station. Medicines requiring refrigeration were also stored as per policy. The medication fridge and medication room temperatures are monitored daily, and the temperatures were within acceptable ranges. Short-life medications were not always dated on opening or discarded as per policy. There was a supply of over the counter 'stock' medications available for resident use; however, these were not charted for residents. Staff were observed to be safely administering medications with processes observed to be as per policy. The registered nurse and caregivers interviewed could describe their role regarding medication administration and management. Controlled drugs are stored correctly; however, the documentation and reconciliation are not as per policy. In the absence of completed medication competencies and no evidence of medication training, the administration of controlled drugs by caregiving staff in the rest home is considered high risk. There were residents at the time of audit receiving

		both regular and pro re nata (PRN) controlled drugs. The effectiveness of 'as required' medications is not always recorded in the electronic medication system and or in the progress notes. Ten electronic medication charts were reviewed. The medication charts appraised identified that the GP had reviewed all resident medication three-monthly, and each medication chart has photo identification and allergy status identified. There was one resident self-administering their medications; however, the resident does not have a current medication competency, and medications are not stored securely in the resident's room as per policy. There have been no medication errors documented since 2021; however, a medication error was discussed at a recent staff meeting and there was no corresponding incident form. The service does not use standing orders.
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. The cook advised they were able to provide food appropriate to Māori residents and their cultural needs. The cook (interviewed) ensures new residents' preferences are accommodated. Copies of individual dietary preferences were available in the kitchen folder. A food control plan is in place, and this expires at the end of February 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 and whānau receive the necessary support during their	FA	Transfer information printed from the electronic resident management system is utilised when residents are required to be transferred to the public hospital or another service. Residents and their family/whānau are involved in all discharges and transfers to and from the service and there was sufficient evidence in the residents' records to confirm this. Records sampled evidenced that the transfer and discharge planning included risk

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.		mitigation and current residents' needs.
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	A current building warrant of fitness is displayed (expiry 1 August 2026). The previous partial attainment # 4.1.1 related to the CPU attainment has been addressed. There is a proactive and reactive maintenance programme (link # 2.2.4). All bio-medical equipment has been calibrated however electrical equipment has not been checked biennially as per policy. Water temperatures are monitored and recorded with those sighted being within range described in policy. Residents and family/whānau interviewed were happy with all aspects of the environment. Spaces were culturally inclusive and suited the needs of the resident groups. The new wing including five bedrooms, the registered nurse office, new laundry and dining room refurbishment including painting, installation of suitable floor coverings and lighting have been completed since the last audit. All rooms have flowing soap, a basin and paper handtowels. Landscaping has been completed including handrails and provision of shade. The previous partial attainment # 4.1.2 related to the partial provisional audit have been addressed.
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	Emergency management procedures guide staff to complete a safe and timely evacuation of the facility in the case of an emergency. There is an updated existing fire evacuation scheme is in place for the facility approved by the New Zealand Fire Service in 2002. A trial fire evacuation drill was held before occupancy of the new wing, and this is repeated every six months. The previous partial attainment # 4.2.1 has been addressed. Members of the Trust and the manager on interview confirmed the availability of local generators in the event of a power outage. With the redevelopment, there is now an electrical outlet plug for a generator to be

		used in the event of an emergency. Staff were provided with training on the need for electrician input to assist with generator procedures. There are two local electricians available to provide this service. The previous partial attainment # 4.2.3 has been addressed. A minimum of one person trained in first aid is always available. An upgraded call bell system has been installed and is fully operational. Staff have been provided with training. Maintenance records confirmed regular checks. Residents and family/whānau interviewed confirmed that call bells are answered in a timely manner. The previous partial attainment #4.2.5 has been addressed.
Subsection 5.2: The infection prevention programme and implementation The people: I trust my provider is committed to implementing policies, systems, and processes to manage my risk of infection. Te Tiriti: The infection prevention programme is culturally safe. Communication about the programme is easy to access and navigate and messages are clear and relevant. As service providers: We develop and implement an infection prevention programme that is appropriate to the needs, size, and scope of our services.	FA	The RN oversees and coordinates the implementation of the infection prevention and control (IPC) programme. The infection prevention and control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team (manager, the RN, and staff) and training and education of staff. Policies and procedures are reviewed by the external consultant in consultation with the RN (link # 2.1.4 for Trust approval). Policies are available to staff. An annual review of the programme is documented. The infection prevention and control policy states that 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. Resident education occurs as part of the daily cares. Residents and families/whānau have been kept informed and updated on any outbreaks if these occur through phone calls and emails. The infection prevention and control (IPC) coordinator is responsible for ensuing staff receive ongoing education. The IPC coordinator (RN) has completed recent external training relevant to their role.
Subsection 5.3: Antimicrobial stewardship (AMS) programme and implementation The people: I trust that my service provider is committed to	FA	There is an antimicrobial use and stewardship policy that covers leadership commitment, accountability, drug expertise, action, tracking, reporting and education. The antimicrobial policy is appropriate for the size, scope, and complexity of the resident cohort. Compliance on

responsible antimicrobial use. Te Tiriti: The antimicrobial stewardship programme is culturally safe and easy to access, and messages are clear and relevant. As service providers: We promote responsible antimicrobials prescribing and implement an AMS programme that is appropriate to the needs, size, and scope of our services.		antibiotic and antimicrobial use is collated, evaluated, analysed. The information is discussed at staff meetings and included in the registered nurses' report to the Trust (link # 2.2.2). Prophylactic use of antibiotics is not considered to be appropriate and is discouraged. The antimicrobial use and stewardship policy as part of the infection prevention and control programme, has not been approved by the Trust (link # 2.1.4). The previous partial attainment # 5.3.1 and # 5.3.3 have been addressed.
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	Infection surveillance is an integral part of the infection prevention and control programme and is described in policy. Monthly infection data is collected for all infections based on signs, symptoms, and definition of infection. Infections are entered into the infection register on the electronic risk management system. Surveillance of all infections (including organisms) is entered onto a monthly infection summary. This data is monitored and analysed for trends, monthly and annually. Infection prevention and control surveillance data is discussed at two monthly staff meetings, with the manager attending these meetings. The service incorporates ethnicity data into surveillance methods and data captured around infections and this is discussed in the meeting minutes. Action plans are documented in the resident file for any infection rates of concern. Internal infection control audits are completed with corrective actions for areas of improvement. The service receives information from Health NZ for any community concerns. There has been no infectious outbreaks since the last audit.
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	FA	The safe and hygienic collection and transport of laundry items was witnessed. All laundry inclusive of resident's clothing is done on site in a new laundry. The new laundry includes a glass screen separating the laundry from the sluice and sanitiser. The laundry has a dirty to clean flow and laundry and cleaning chemicals are stored securely. Policies and procedures have been updated to reflect the changes and staff have received related training. The sanitiser is operational. Visual inspection of the on-site laundry demonstrated the implementation of a clean/dirty process for the hygienic washing, drying, and handling of these items.

environment that facilitates the prevention of infection and transmission of antimicrobial resistant organisms.		There is a sluice cycle programmed in one washing machine. Residents' clothing is labelled and personally delivered from the laundry to their rooms. The effectiveness of the cleaning and laundry processes are monitored through the internal audit system, with oversight from the infection prevention and control coordinator. Residents and family/whānau confirmed satisfaction with laundry services in interviews. The previous partial attainment # 5.5.4 has been addressed.
Subsection 6.1: A process of restraint The people: I trust the service provider is committed to improving policies, systems, and processes to ensure I am free from restrictions. Te Tiriti: Service providers work in partnership with Māori to ensure services are mana enhancing and use least restrictive practices. As service providers: We demonstrate the rationale for the use of restraint in the context of aiming for elimination.	FA	The facility is committed to providing services to residents without the use of restraint. The restraint policy confirms that restraint consideration and application must be done in partnership with family/whānau, and the choice of device must be the least restrictive possible if ever used. There was no restraint used on the days of audit. The service has remained restraint free since the last audit. The restraint coordinator (RN) was interviewed, and they described the organisation's commitment to 'no restraint'. Staff were observed to use interventions documented in care plans to de-escalate and manage any challenging behaviour. Training and competencies were completed in June 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 1.8.3 My complaint shall be addressed and resolved in accordance with the Code of Health and Disability Services Consumers' Rights.	PA Moderate	There was evidence that complaints are a standard agenda item at staff meetings, and the board is informed by monthly reports from the manager and registered nurse. Policy states that informal complaints should be lodged in the electronic complaint system; however, a verbal complaint received in July 2025 and discussed at a staff meeting was not included in the electronic complaint register.	i) Documented complaints did not evidence compliance with acknowledgement, investigation and outcome timeframes as per policy or health and disability commission guidelines. ii) The complaint process does not evidence investigation or outcome documentation. iii). A concern raised by family in July 2025 (documented in staff meeting minutes) was not documented in the complaints register.	i). Ensure complaints are responded to and outcomes concluded within policy and health and disability commission timeframes. ii). Ensure complaint acknowledgement, investigation and outcomes are documented. iii)Ensure all complaints are documented in the complaints register. 30 days
Criterion 2.1.4 Governance bodies shall	PA Moderate	Whalan Lodge has a documented quality and risk plan with meetings	The business plan does not provide evidence of the Trust's	Ensure there is evidence of the Trust's sign off of the Whalan

evidence leadership and commitment to the quality and risk management system.		and data collation. An internal audit schedule is in place. The 2024 – 2025 business plan is in place with identified objectives; however, the business plan does not evidence the Board has signed off the quality and risk management programme	sign off of the Whalan Lodge quality and risk management system, including restraint management, infection prevention control and management, antimicrobial stewardship, or reference the Māori and Pasifika health plans.	Lodge quality and risk management system, to include restraint management, infection prevention control and management, antimicrobial stewardship, and the Māori and Pasifika health plans. 60 days
Criterion 2.2.2 Service providers shall develop and implement a quality management framework using a risk-based approach to improve service delivery and care.	PA Moderate	There is a quality management framework documented for the service but not fully implemented. An internal audit schedule was documented for 2024, and 2025; and completed as per schedule; however, not all audits were evidenced as completed and where shortfalls were identified in audits finished, there was not always evidence of resolution or improvements to the service or care made.	i).The information collected by internal audits and the corrective actions are not discussed in sufficient detail in meetings to ensure any outstanding matters are addressed with sign-off when completed. ii).Annual satisfaction surveys have not been implemented since 2023. iii). Non-clinical internal audits had not been signed off as completed on the day of audit. iv). Not all corrective actions identified at internal audits were evidenced as being closed off. v). The management report to the Trust does not consistently include quality indicators including health and safety, complaints, human resource concerns or internal audit and corrective action information. vi). Meeting minutes are stored in a folder in the manager's office	i). Ensure internal audit results and corrective actions are discussed in sufficient detail in staff meetings. ii).Ensure annual resident and family satisfaction surveys are implemented as scheduled. iii). Ensure non-clinical internal audits are signed off when completed. iv).Ensure corrective actions are implemented and closed off when finalised. v). Ensure management reports to the trust include health and safety, complaints, human resource concerns or internal audit and corrective action information. vi).Ensure meeting minutes are available for staff. 60 days

			and are not available to staff.	
Criterion 2.2.4 Service providers shall identify external and internal risks and opportunities, including potential inequities, and develop a plan to respond to them.	PA Moderate	The organisational risk management plan, an electronic hazard register and a maintenance schedule have not been evidenced as updated or reviewed since 2023. The documents support the identification of external and internal risks and potential for opportunities to respond when risks are identified.	i). The organisational risk management plan, an electronic hazard register and a maintenance schedule have not been evidenced as updated or reviewed in 2024 or 2025. ii). There was no evidence registers are updated in response to new, emerging or changes in risk.	i). & ii). Ensure the organisational risk management plan, the electronic hazard register and maintenance schedule are evidenced as being reviewed at regular intervals and ongoing as new risks are identified. 60 days
Criterion 2.3.4 Service providers shall ensure there is a system to identify, plan, facilitate, and record ongoing learning and development for health care and support workers so that they can provide high-quality safe services.	PA Moderate	A training schedule/plan was documented in 2024 and 2025 which incorporated required competencies; however, did not include all required training as per the ARRC contract. Individual training records and attendance sheets do not reflect all caregivers have completed at least eight hours of education. All staff including the RN were confirmed has having a current first aid certificate. The manager has a current first aid certificate. There is evidence that there is always a staff member or manager with a current first aid certificate on site. The manager and the staff were knowledgeable around clinical concerns and care to be provided when interviewed.	i). This audit could not evidence that caregivers have completed training relevant to their role (and the NZS 8134:2021) in the past two years to meet the ARRC contract clause D17.7. ii). Competencies have not been completed annually as per policy for medication, hand hygiene, cultural safety and PPE. iii). The manager was unable to evidence training related to aged care facility management for 2025. iv). Training was not evidenced for the following subjects documented as annual training: code of consumer rights, abuse and neglect, cultural safety, food and nutrition, medication management, and sexuality and intimacy.	i).Ensure caregivers training evidence meets the ARRC Contract clause D17.7 ii).Ensure competencies are completed annually as scheduled. iii).Ensure the manager completes education related to aged care facility management. iv).Ensure all required training is provided as scheduled. 90 days

		Following the draft report the registered nurse provided feedback that Abuse and neglect and sexuality and intimacy training frequency is biennial and was completed on September 12th 2024 with Age care Otago. Medication competencies were in the process of being completed at the time of the audit. These were started on the 5th December and all completed by the 23rd December.		
Criterion 2.4.2 Service providers shall ensure the skills and knowledge required of each position are identified and the outcomes, accountability, responsibilities, authority, and functions to be achieved in each position are documented.	PA Low	There are documented position descriptions in place for all employment roles. Three staff had position descriptions on their individual files.	Two of five staff files reviewed did not have a position description in file.	Ensure all staff have signed position descriptions on file. 90 days
Criterion 2.4.4 Health care and support workers shall receive an orientation and induction programme that covers the essential components of the service provided.	PA Moderate	A staff orientation policy is documented. Five staff files were reviewed. All staff had been employed for over three months. Two staff had completed orientations on file. One staff member had an orientation on file; however, this was not completed.	i).Two of five staff files reviewed did not have evidence of an orientation on file. ii). One of three orientations on file was not fully completed.	I – ii). Ensure fully completed orientation is evidenced for all staff. 60 days

Criterion 2.4.5 Health care and support workers shall have the opportunity to discuss and review performance at defined intervals.	PA Moderate	An appraisal policy and schedule is in place. Five staff files were reviewed. One of these staff files had an appraisal completed and one staff member had not been at Whalan Lodge long enough to have an appraisal. A further three files required a performance appraisal; however, there was no evidence of a completed performance appraisal in the file.	Three of three staff files reviewed who had been employed for over a year did not have a current performance appraisal on file.	Ensure appraisals are completed as per the schedule. 60 days
Criterion 3.4.1 A medication management system shall be implemented appropriate to the scope of the service.	PA High	Medication is stored in locked cupboards or a secure trolley in the nurse's station. The cupboard and trolleys are locked and are stored in an area that is not accessible to residents, visitors or unauthorised staff. There is a small supply of stock drugs kept on site (over the counter medications) which the manager was aware of. Policy requires the effectiveness of 'as required' medications to be recorded in the electronic medication system and/or in the progress notes; however, not all as required medications had effectiveness documented. There are robust policies and procedures in place related to management of controlled drugs; however, these were not always fully implemented. The controlled drug register documentation did not always comply with legislation or	i). One controlled medication (oxycodone) was not documented in the reference index of the controlled drug register. ii). The controlled drug register reference index identified the medication name and dosage; however, six entries did not record the name of the rest home resident. iii). The controlled drug register did not accurately reflect current medications, eg: morphine liquid documented on two pages; however, only one bottle in the cupboard. iv). Controlled drug register documentation did not always evidence two signatures of staff who have completed medication competencies related to controlled drug administration.	i). Ensure that all controlled drugs transactions are documented in the index of the controlled drug register. ii) Ensure the controlled drug index records the medication and the resident's name. iii). Ensure the controlled drug register accurately reflects the controlled medications on site. iv) Ensure all controlled medication administration reflect two signatures of staff who have completed medication competencies related to controlled drug administration. v) Complete stock takes of the controlled drugs weekly and six monthly as scheduled. vi). Ensure as required medications are administered in accordance with policy and the

		policy. A review of weekly checks and six-monthly checks identified that checks had not always been completed. The non-compliance of several areas related to the medication system is viewed as high risk.	v). Stocktakes of the controlled drug register were not always completed weekly and quantity stocktakes were not always implemented six monthly. vi). 'As required' opioid medications are administered by caregivers without consultation with an RN. vii). Three of three short-life medications were not discarded within required timeframes and remained in use at the time of audit. viii). A short-life ointment had not been dated on opening. ix). The effectiveness of as required documentation was not always documented.	Medicines Care Guide for Residential Aged Care. vii- viii). Ensure short life medications are dated on opening and discarded as per manufacturer's instructions. ix). Ensure the effectiveness of as required medications is documented. 7 days
Criterion 3.4.2 The following aspects of the system shall be performed and communicated to people by registered health professionals operating within their role and scope of practice: prescribing, dispensing, reconciliation, and review.	PA Moderate	The registered nurse has a medication competency. The registered nurse is responsible for reconciliation of medications and the manager for oversight of implementation of the policy. The Medicine care guides for aged residential care is referenced in the medication policy; however: For those residents who have recently started a controlled drug there were no evidence that a clinical assessment has been completed by a registered nurse to support clinical judgement. Or if the rest	For those residents who have recently started a controlled drug, there was no evidence that a clinical assessment has been completed by a registered nurse to support clinical judgement; or the RN stated the resident is stable and does not require regular assessments.	Ensure the RN completes a clinical pain assessment. 60 days

		home residents who requires controlled drugs are stable and not requiring frequent clinical assessment. There were residents at the time of the audit receiving regular and 'prn' opioids.		
Criterion 3.4.3 Service providers ensure competent health care and support workers manage medication including: receiving, storage, administration, monitoring, safe disposal, or returning to pharmacy.	PA High	The staff training policy requires medication competencies to be repeated annually. The medication policy requires staff who administer medications to have a medication competency related to oxygen administration, insulin administration, controlled drug administration and second checker. One staff member had a current medication competency. The registered nurse is responsible for reconciliation of medications and the manager for oversight of implementation of the policy. The registered nurse has a medication competency. The manager (a caregiver) did not evidence a current medication competency. There are nine caregivers who routinely administer medications; however, the majority of caregivers did not have a current medication competency. The last medication competencies were sighted as being completed in December 2023 and March 2024. Since the draft report the registered nurses stated education and competencies were in progress at	i).Medication competencies have not been completed annually for eight of nine caregivers who administer medications. ii).The manager (caregiver) did not have a medication competency.	i-ii).Ensure that all managers and staff involved in medication administration have completed annual medication competencies. 7 days

		the time of the audit. All were completed throughout December.		
Criterion 3.4.4 A process shall be implemented to identify, record, and communicate people's medicine related allergies or sensitivities and respond appropriately to adverse events.	PA Moderate	Ten electronic medication charts were reviewed. The medication charts examined identified that allergy status was documented. A medication error was identified and addressed by the registered nurse. This included documented evaluation of the cause and corrective actions. The incident was discussed at a staff meeting; however, the error was not included in the adverse events form as part of incident reporting and quality system.	A medication error identified in meeting minutes relating to controlled medication was not entered into the electronic adverse events or included in the quality reporting system.	Ensure all medication incidents are included in the quality reporting system 30 days
Criterion 3.4.6 Service providers shall facilitate safe self-administration of medication where appropriate.	PA Moderate	Residents who wish to self-medicate are supported to do so by ensuring adequate supplies. Policy states residents who self-administer medications have a competency signed by a medical practitioner, reviewed three monthly and are safely and securely stored; however, this is not always implemented.	i).One resident who self-administers their insulin did not have a self-medication competency. ii). Pre-filled Insulin syringes were stored on the residents overbed table in the residents room.	i).Ensure all residents who self-administer medications have a current competency on file as per policy. ii). Ensure medication of self-administering residents in stored securely in their rooms. 30 days
Criterion 3.4.8 Over-the-counter medication and supplements shall be	PA Moderate	There is a stock supply of communal over-the-counter medications which are administered by caregivers. The manager was aware of this as confirmed on	i).Stock medication (e.g.codral, kurols, antiflame etc) is available for use. ii) Over the counter medication is	i).Ensure there is no stock medication in use for rest home level care residents. ii). Ensure all over the counter

considered by the prescriber as part of the person's medication.		interview. There was no evidence that over-the-counter medications were considered or prescribed by the GP or nurse-initiated orders documented.	administered to residents without a prescription and without evidence that it is considered at medication review or as part of a nurse-initiated order.	medications are prescribed prior to administration. 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	The building has a current warrant of fitness, and all bio medical equipment has been checked however testing of electrical equipment has not been completed.	Electrical testing of equipment has not been completed since October 2023.	Ensure electrical appliances are checked as scheduled. 90 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

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End of the report.