Kindred Hospital Limited - Kindred Hospital

Introduction

This report records the results of a Certification 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: Kindred Hospital Limited

Premises audited: Kindred Hospital

Services audited: Hospital services - Psychogeriatric services

Dates of audit: Start date: 15 January 2026 End date: 16 January 2026

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: 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 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

Kindred Hospital is a privately owned facility that provides psychogeriatric level care for up to 44 residents. At the time of the audit there were 40 residents in total.

This certification audit was conducted against the relevant Ngā Paerewa Health and Disability Services Standard 2021 and the contract with Health New Zealand. The audit processes included observations; a review of organisational documents; staff and resident files; and interviews with family/whānau, staff, management, and a general practitioner.

An experienced clinical manager (registered nurse) oversees the operations of the facility for two days a week, along with the owner/manager and the facility manager. All managers provide oversight and expertise across this and a second sister facility. Family/whānau reported that they were satisfied with cares provided.

This certification audit has identified areas of improvement around complaints management; facility management and clinical leadership; implementation of the quality systems; incident management; staff training and competencies; entry to service; care plan interventions and evaluations; activities; medicine management; food services; physical environment; civil defence processes; pandemic planning and outbreak management; infection control and cleaning processes; and restraint management.

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.

Kindred Hospital provides an environment that supports resident rights and safe care. Staff demonstrate an understanding of residents' rights. A Māori health plan is in place for the service. Māori mana motuhake is recognised in all aspects of service delivery, using a strengths-based and holistic model of care. Staff encourage participation in te ao Māori.

A Pacific health plan is documented. Policies are in place around the elimination of discrimination, harassment, and bullying. Consent forms are signed appropriately. There is a documented policy for the management of complaints that meets guidelines established by the Health and Disability Commissioner.

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.

There is a documented organisational structure. Services are planned and coordinated by the managers, with input from family/whānau. The owner/manager, clinical manager and the facility manager oversee both Kindred Hospital and the sister site that is also in Auckland. The business plan informs the site-specific operational objectives which are reviewed on a regular basis.

The service has a documented quality and risk management system. Internal audits were all documented as taking place as scheduled, with corrective actions as indicated. There are monthly staff meetings held. An independent consultant with expertise in aged care provides support for the management team and staff when required. Health and safety systems are in place for hazard reporting and management of staff wellbeing. Family/whānau reported that staffing levels are adequate to meet the needs of the residents. There are documented processes for management of adverse events.

The service has an orientation programme in place that provides new staff with relevant information for safe work practice. There is a training plan that aims to ensure that staff keep practice up to date. There is a staffing and rostering policy documented. Staff performance is reviewed.

The service ensures the collection, storage, and use of personal and health information of residents is secure, accessible, and confidential.

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.

Entry into the facility is managed in a safe, timely and equitable manner. Registered nurses are responsible for assessment, care planning, and evaluation of care. Family/whānau interviewed expressed they are involved at all stages of service delivery. A general practitioner visits the facility weekly to complete medical assessments and medication reviews. Residents have their needs met in a manner that respects their cultural values and beliefs.

Activities are overseen by an activity's coordinator. The formal activities programme is provided seven days per week. There is a varied activities programme that includes van outings and entertainers.

There are policies and processes that describe medication management that align with accepted guidelines. Staff responsible for medication administration have completed annual competencies and education. All medication charts were completed correctly and evidenced allergies and sensitivities.

All meals and baking are prepared and cooked on site. Nutritional needs and preferences of residents are identified on admission and during regular reviews. There is a current food control plan. The menu caters for cultural preferences and has been reviewed by a dietitian. Dietary needs, allergies, intolerances, and preferences are catered for.

Discharge and transfer are managed safely in collaboration with family/whānau.

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

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

There is a current building warrant of fitness. There is a preventative and reactive maintenance plan implemented. Rooms are spacious to provide personal cares. Residents can freely mobilise within the communal areas. The facility is secure. There is adequate space throughout the facility for residents to move around freely with mobility aids. There are sufficient toilet and bathing facilities. All communal areas have natural light and adequate ventilation.

Appropriate training, information, and equipment for responding to emergencies are provided. There is an emergency management plan in place and adequate civil defence supplies in the event of an emergency. There are emergency supplies for at least three days. There is always a staff member trained in resuscitation skills and first aid on duty. There are appropriate security measures in place overnight.

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

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

The service ensures the safety of residents and staff through a planned infection prevention and antimicrobial stewardship programme that is appropriate to the size and complexity of the service. The infection control coordinator (registered nurse) coordinates the programme. There is a documented pandemic plan in place and outbreak management processes.

The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Surveillance results are shared with all staff. Follow-up action is taken as

and when required. There have been outbreaks since the previous audit. There are documented processes that support the prevention and transmission of infections.

There are designated staff rostered to ensure the environment and facility are kept clean. Waste and hazardous substances are well managed. There are safe and effective laundry services.

Here taratahi | Restraint and seclusion

Includes four subsections that support outcomes where Services shall aim for a restraint and seclusion free environment, in which people’s dignity and mana are maintained.		Some subsections applicable to this service are partially attained and of medium or high risk and/or unattained and of low risk.

A registered nurse is the restraint coordinator. There is a restraint committee in place that oversee all aspects of restraint. Family/whānau are involved in any decisions relating to restraint. The service follows a consent, approval, monitoring, and evaluation process in accordance with the Standard. During the audit there were residents using restraint.

Staff receive training on the policy and procedures as part of orientation. Thereafter staff receive annual education on restraint minimisation and safe practice and are required to demonstrate their competency.

A restraint register is maintained.

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	13	0	4	12	0	0
Criteria	0	155	0	5	16	0	0

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

Attainment against the Ngā paerewa Health and disability services standard

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

For more information on the standard, please click here.

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

Subsection with desired outcome	Attainment Rating	Audit Evidence
Subsection 1.1: Pae ora healthy futures Te Tiriti: Māori flourish and thrive in an environment that enables good health and wellbeing. As service providers: We work collaboratively to embrace, support, and encourage a Māori worldview of health and provide high-quality, equitable, and effective services for Māori framed by Te Tiriti o Waitangi.	FA	A Māori health plan is documented for the service. The plan acknowledges Te Tiriti o Waitangi as a founding document for Aotearoa New Zealand. The aim is to co-design health services using a collaborative and partnership model with Māori. At the time of the audit there were residents who identified as Māori. An interview with the clinical manager confirmed that residents who identify as Māori will be supported to maintain their links in the community, and family/whānau participation and involvement in the review of care plans. There are clear processes to include tikanga in everyday practice. Policies and procedures have been developed by an external contractor with input from Māori. Kindred Hospital has internal cultural support through family/whānau of residents in the service who assist the staff and management team with enacting the Māori health plan, thus demonstrating commitment by the organisation to respecting the self-determination, cultural values, and beliefs of Māori residents and family/whānau. The service can also access kaumātua from Health New Zealand for support and guidance. Cultural assessments are completed for residents who identify as Māori. The Māori health plan states the organisation seeks to actively

		increase Māori workforce through targeted recruitment, and Māori staff are provided with equal opportunities to develop their knowledge and skills. There were no staff who identified as Māori at the time of the audit. Interviews with ten staff (including one registered nurse (RN), one clinical nurse leader, five caregivers, one cleaner, one cook, and one activities coordinator) described examples of providing culturally safe services in relation to their role. Family/whānau are involved in providing input into the resident's care planning, their activities, and their dietary needs. Clinical staff described their commitment to supporting any Māori residents and their family/whānau by identifying what is important to them. This includes their individual values and beliefs, enabling self-determination and authority in decision-making that supports their health and wellbeing. Interviews with the management team (including one clinical manager, one facility manager, and the owner/manager) identified the service is focused on delivering person-centred care, which includes operating in ways that are culturally safe. Staff have completed cultural safety training and competency in October 2025.
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 Pacific peoples for improved health outcomes.	FA	There is a Pacific health plan in place which aims to uphold the principles of Pacific people by acknowledging respectful relationships, valuing family/whānau and providing equitable quality healthcare. On admission all residents state their ethnicity and provide cultural beliefs information. Individual cultural beliefs are documented for all residents in their care plans. At the time of the audit, there were residents who identified as Pasifika. The service maintains a link with a local Pacific Island community group through their staff, to provide cultural support for Pacific peoples when required. Information on cultural safety of Pacific peoples is provided in the orientation programme for all new employees. Expectations regarding cultural practice is documented in employees' job descriptions and employee handbook. Data collected for Pacific peoples informs targeted health interventions needed. Staff training ensures a culturally safe service.

		At the time of the audit there were staff who identified as Pasifika. The clinical manager and facility manager stated the recruitment processes is equitable to support Pacific applicants. Interviews with the management team, staff, family/whānau and documentation reviewed identified that the service puts people using the services and family/whānau at the heart of their services.
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	The Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is displayed in English and te reo Māori. The service ensures that Māori mana motuhake is recognised in all aspects of service delivery, as evidenced in the Māori health plan, interviews with staff, and review of the education, training, and resident care plans. The organisation's policies and procedures align with the requirements of the Code. The clinical manager and facility manager discuss aspects of the Code with family/whānau and information about the Nationwide Health and Disability Advocacy Service is made available to them. Other formats are available, such as information in te reo Māori, Chinese and Pacific languages. The staff interviewed confirmed their understanding of the Code and its application to their specific job role and responsibilities. Staff receive education in relation to the Code at orientation and there is a plan to ensure staff receive training related to resident rights, that includes (but not limited to) understanding the role of advocacy services (link 2.3.4). Advocacy services are linked to the complaints process. Seven family/whānau interviewed stated they felt residents' rights were upheld and they were treated with dignity, respect, and kindness, and were encouraged to recognise Māori mana motuhake.
Subsection 1.4: I am treated with respect The People: I can be who I am when I am treated with dignity and respect. Te Tiriti: Service providers commit to Māori mana motuhake. As service providers: We provide services and support to people in	FA	Caregivers and registered nurses interviewed described how they support residents to choose what they want to do and provided examples of the things that are important to residents, which then shape the care and support they receive. Family/whānau interviewed reported that residents are supported to be independent and are encouraged to make a range of choices around their daily life, and

a way that is inclusive and respects their identity and their experiences.		what activities they wished to participate in. The service responds to residents' needs and enables their participation in te ao Māori. The service`s two yearly training plan demonstrates training that is responsive to the diverse needs of people across the service. A sexuality and intimacy policy is in place. There is a plan to ensure that staff receive training on sexuality and intimacy as part of the education schedule (link 2.3.4). The spirituality policy is in place and is understood by care staff. Staff described how values and beliefs information is gathered on admission with family/whānau involvement, and is integrated into the residents' care plans. Spiritual needs are identified, and spiritual support is available. Family/whānau interviewed were positive about the service in relation to residents' values and beliefs being considered and met. Privacy is ensured and independence is encouraged. The storage and security of health information policy is implemented. Orientation for staff covers the concepts of personal privacy and dignity. Residents' files and care plans identified resident's preferred names. Te reo Māori is celebrated during Māori language week and Matariki celebrations. The service has signage in te reo Māori displayed in various locations throughout the facility. The staff noticeboards contain information on Māori tikanga practice. Interviews with management and staff confirmed their understanding of tikanga best practice. Cultural training is also included in the orientation programme for new staff. Cultural safety training that covers Te Tiriti o Waitangi and tikanga Māori was completed in October 2025.
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	There is an abuse and neglect policy documented which is understood by staff. This policy describes how staff ensure the service is free from any form of discrimination, coercion, harassment, or any other exploitation. The organisation is inclusive of ethnicities, and cultural days celebrate diversity. A staff code of conduct is discussed during the employee's induction to the service, with evidence of staff signing the code of conduct policy. The code of conduct (titled 'House Rules') states discrimination, harassment, and bullying will not be tolerated. All staff are held responsible for creating a positive, inclusive and a safe working environment. The service implements a process to manage residents' expenses through an

		invoicing and receipting system to family/whānau, and there are safeguards to ensure resident property is respected and protected. Professional boundaries are defined in job descriptions and are also covered as part of orientation. Interviews with registered nurses and caregivers confirmed their understanding of professional boundaries, clinical bias, and the impact of institutional racism. Staff complete education at orientation on how to identify abuse and neglect, and how to value the older person, showing them respect and dignity. During the interview with caregivers, they were all able to describe examples of what neglect and abuse may look like. Family/whānau interviewed confirmed that the staff are caring, supportive and respectful. This was also supported by the family/whānau satisfaction survey. The service promotes a strengths-based and holistic model to ensure wellbeing outcomes would be prioritised for Māori residents. On interview, care staff confirmed an understanding of holistic care for all residents.
Subsection 1.6: Effective communication occurs The people: I feel listened to and that what I say is valued, and I feel that all information exchanged contributes to enhancing my wellbeing. Te Tiriti: Services are easy to access and navigate and give clear and relevant health messages to Māori. As service providers: We listen and respect the voices of the people who use our services and effectively communicate with them about their choices.	FA	Kindred Hospital has policies and procedures relating to accident/incidents, complaints and open disclosure that alert staff to their responsibility to notify family/whānau of any adverse event. The service utilises electronic accident/incident forms, which has a section to indicate if the family/whānau have been informed (or not). Twelve incident forms reviewed evidenced family/whānau were notified on all occasions. An interpreter policy and contact details of interpreters is available. Support strategies and interpretation services are documented to assist with communication needs when required. Family/whānau are informed prior to entry of the scope of services and any items that are not covered by the agreement. Family/whānau stated they are provided with information when requested and time to discuss concerns. The service communicates with other agencies that are involved with the resident, such as the local hospice and Health New Zealand. The delivery of care includes a multidisciplinary team, and the activated enduring power of attorney (EPOA) or welfare guardian provides

		consent and are involved in all decision-making in partnership with the services involved. The clinical manager described the process around providing family/whānau with time for discussion around care, time to consider decisions and opportunity for further discussion if required. Family/whānau interviewed confirm they know what is happening within the home through emails.
Subsection 1.7: I am informed and able to make choices The people: I know I will be asked for my views. My choices will be respected when making decisions about my wellbeing. If my choices cannot be upheld, I will be provided with information that supports me to understand why. Te Tiriti: High-quality services are provided that are easy to access and navigate. Providers give clear and relevant messages so that individuals and whānau can effectively manage their own health, keep well, and live well. As service providers: We provide people using our services or their legal representatives with the information necessary to make informed decisions in accordance with their rights and their ability to exercise independence, choice, and control.	FA	There are policies around informed consent. Informed consent processes are discussed with family/whānau on admission. Seven resident files reviewed had written general consents signed by the enduring power of attorneys (EPOA) or welfare guardians. Consent for release of medical information and medical cares are included in the admission agreement and signed as part of the admission process. Specific consents had been signed by EPOAs or Welfare guardians for procedures such as influenza and Covid-19 vaccines. Discussions with caregivers confirmed that they are familiar with the requirements to obtain consent for entering rooms and undertaking personal cares. All the files reviewed had either EPOA or current welfare guardian documentation on file. The EPOA documentation is filed and activated, with certificate for incapacity sighted in files reviewed. Advance directives for health care, including resuscitation status, were in place in resident files. Where a medically initiated resuscitation decision had been documented, there was documented evidence of discussion with the EPOA or welfare guardian. The service follows relevant best practice tikanga guidelines, welcoming the involvement of family/whānau in decision making. Discussions with family/whānau confirmed that they are involved in the decision-making process, and in the planning of resident's care.
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	PA Moderate	There is a documented complaints policy which meets the guidelines as set by the Health and Disability Commissioner (HDC). The complaints policy includes use of te reo Māori, and references support for Māori residents to ensure the process works equitably for Māori residents. Complaints forms and a suggestion box are in a

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.		visible location at the entrance to the facility and can be accessed from staff. Those making a complaint can involve an independent support person/advocate in the process if they choose to do so. Discussions with family/whānau confirmed they are provided with information on the complaints process. The clinical manager has responsibility for ensuring all complaints (verbal and written) are fully documented and investigated. A complaints register is being maintained; however, this has not been kept updated. The process documented in the complaints register provides details regarding dates, timeframes, complaints, and actions taken. Although there have been two complaints since the last audit, these have not been documented in the register. These include one anonymous complaint submitted via Health New Zealand in July 2025 and one internal complaint in 2026 year to date. Documentation including an investigation, follow-up letters, action plans, and resolution were not evident. Review of the facility meeting minutes evidence that there are opportunities to discuss concerns and complaints as they arise. The clinical manager acknowledged the understanding that for Māori, there is a preference for face-to-face communication. Family/whānau confirmed that management are open and transparent in their communications, and staff clearly explained the complaint process, ensuring they knew how to raise any concerns.
Subsection 2.1: Governance The people: I trust the people governing the service to have the knowledge, integrity, and ability to empower the communities they serve. Te Tiriti: Honouring Te Tiriti, Māori participate in governance in partnership, experiencing meaningful inclusion on all governance bodies and having substantive input into organisational operational policies. As service providers: Our governance body is accountable for delivering a highquality service that is responsive, inclusive, and sensitive to the cultural diversity of communities we serve.	PA Moderate	Kindred Hospital provides psychogeriatric level of care for up to forty-four beds. On the day of audit, there were forty residents at psychogeriatric level of care, including two on younger person with a disability (YPD). All the remaining residents were under the age-related hospital specialist services (ARHSS) agreement. There are no double/shared rooms. All the rooms are single occupied. Kindred Hospital is the trading name of Kindred Hospital Limited - a privately owned company. It is one of two facilities owned and operated by the owner/manager. Kindred Hospital has a current business plan in place, with clear goals to support their documented vision, mission, and values. The values advocate caring, and

		personalised care. The business plan describes annual and long-term business objectives and the associated operational plans. The business plan reflects a leadership commitment to collaborate with Māori, aligns with the Ministry of Health strategies, and addresses barriers to equitable service delivery. The service has a Māori and Pacific health plan, which states the service will provide services in a culturally appropriate manner to achieve equitable health outcomes for Māori and Pacific people, including services for tāngata whaikaha. Policies and procedures have been developed by an external contractor, with input from Māori. The annual resident survey evidenced improved outcomes and equity for tāngata whaikaha people with disabilities. Collaboration with family/whānau who identify as Māori and/or tāngata whaikaha reflect their input for the provision of equitable delivery of care. The monthly staff meetings provide an opportunity to review the day-to-day operations and to review progress towards meeting the business objectives. The owner/manager interviewed on the day of the audit was knowledgeable around legislative and contractual requirements and is experienced in the aged care sector, having owned and managed aged care facilities for several years. The clinical manager and the general practitioner provide oversight with clinical governance. The owner/manager is hands-on and involved in the operations and oversight of the two facilities. The day-to-day operations are overseen by the facility manager (non-clinical) and a clinical manager, who is a registered nurse with a current practicing certificate, who has been in the role since 2023. They both provide oversight of the two sister facilities. The facility manager spends two days on site at Kindred Hospital and the clinical manager two to three days dedicated to Kindred Hospital each week. The set up provides limited clinical oversight of Kindred Hospital by the clinical manager. A team of registered nurses, caregivers, cleaning, activities, and kitchen staff supports the management. The facility manager and clinical manager have maintained the required hours of professional development activities related to managing an aged care facility, including (but not limited to) attendance at the regional aged care meetings, EPOA and PPPR,

		and behavioural and psychological symptoms of dementia. Policies and procedures have been developed by an external contractor with input from Māori. The service has processes in place to achieve equity for Māori; and to identify and address barriers for Māori for equitable service delivery. This includes internal cultural support from family/whānau of residents in the service who assist the staff and management team with enacting the Māori health plan through annual service reviews thus demonstrating commitment by the organisation to respecting the self-determination, cultural values, and beliefs of Māori residents and family/whānau. The annual survey evidenced improved outcomes and equity for Māori and tāngata whaikaha people with disabilities. The owner/manager, facility manager and clinical manager have completed cultural safety training and competency to ensure knowledge around Te Tiriti, health equity, and cultural safety
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	A quality and risk management programme is documented. The quality and risk management systems include performance monitoring through internal audits and through the collection of clinical indicator data. Monthly staff meetings provide an avenue for discussions in relation to (but not limited to) quality data; health and safety; infection control/pandemic strategies; complaints received (if any); staffing; and education. Quality data reported includes falls; behaviour incidents; bruises; pressure injures; skin tears; infections; medication errors; and restraint use. Monthly internal audits and collation of data were completed as scheduled since the last audit. Comparison of data is used to critically analyse Kindred Hospital practices, to ensure health inequities are responded to. Completed internal audits identify corrective actions are documented where indicated to address service improvements. Corrective actions provide evidence of progress and sign off when achieved. A meeting schedule for 2025 has been documented, and meetings have been held according to the schedule, including family/whānau meetings. Discussions with staff confirmed their involvement in the quality programme.

		Quality objectives for 2025 were sighted on the day of the audit, with milestone measures of progress documented and signed off when completed. At the time of the audit the service was in the process of receiving the completed family/whānau satisfaction surveys (sent out in December 2025). Review of the surveys that had been received by the time of the audit demonstrated satisfaction with service delivery. Comments added to the satisfaction surveys were positive. Policies and procedures are held electronically and in hard copy. Policies and procedures are regularly reviewed to ensure all care staff deliver high quality health care for Māori. Staff interviewed confirmed they were able to access policies and relevant documentation, as and when required. A health and safety system is in place, including training, hazard identification, incident and near miss reporting, and investigations. Hazards and risks are documented and addressed appropriately. Hazard identification forms are completed, and an up-to-date hazard and risk register was in place (last reviewed October 2025). Staff are kept informed on health and safety issues in handovers and meetings. Staff received education related to hazard management and health and safety at orientation and annually (February 2025). Electronic entries have not been completed for each incident/accident. When completed, immediate action is documented, signed off by the clinical manager; however, follow-up action(s) required are not always evident. Twelve accident/incident records were reviewed. Incident and accident data is collated monthly and analysed, but has not been collated and analysed annually as per policy. Results are discussed in the staff meetings and at handover. Each event involving a resident reflected follow up by a registered nurse. Neurological observations were not always completed as per policy (link 3.2.3). Discussions with the clinical manager evidenced awareness of their requirement to notify relevant authorities in relation to essential notifications. There have been no Section 31 or Severity Assessment Code (SAC) notifications to the Health Quality and Safety Commission reported since last audit. There have been outbreaks documented since the previous audit, but no evidence of notification

		as required (link 5.4.3).
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	A policy is in place for determining staffing levels and skills mix for safe service delivery and defines staffing ratios to residents. Rosters implement the staffing rationale. The clinical manager works full time from Monday to Friday between Kindred Hospital and the sister facility (link 2.1.3) and provides 24/7 on call for any clinical matters. The facility manager works full time between the two sister facilities and is on call 24/7 for any operations related issues. The clinical manager and facility manager stated that the service has a full complement of registered nurses. Review of the last three weeks roster confirm 24/7 registered nurse cover. A team of registered nurses and caregivers supports the management. Agency staff are not used. There are dedicated activities, kitchen, and cleaning staff supporting service delivery. Care staff interviewed stated there are enough staff on duty to meet the needs of the residents. Family/whānau interviewed stated there were staff available when they visit to meet the needs of the residents. There is a two-yearly education and training schedule; this has not been fully implemented to date. The mandatory training covers a range of topics related to caring for the older person. Kindred Hospital orientation programme ensures core competencies and compulsory knowledge/topics are addressed. The service employs twenty-six caregivers and supports them to obtain a New Zealand Qualification Authority (NZQA) qualification. A review of staff records showed that 13 caregivers have completed the psychogeriatric unit standards; 7 are enrolled and in the process of completing their psychogeriatric unit standards and are within the 18-month period for completion. However, six caregivers have not completed the required unit standards within the 18-month period. The activity coordinator has not completed the required qualifications. The training programme exceeds eight hours annually. Training is conducted face to face, through competency questionnaires, online, and external guest presenters. There are six RNs (excluding the clinical manager), four of them completed interRAI training, but none are syringe driver competent. Registered nurses have attended

		training, including (but not limited to) care planning; motor neurone disease; preventing and understanding dementia; infection prevention and control, including Covid-19 preparedness; and palliative care. There is a range of competencies specific to the employee`s role. There is a schedule and register in place. All registered nurses have current medication competencies, and a selection of caregivers have completed the medication checker competency. Caregivers and registered nurses are required to complete annual competencies for cultural, restraint, and moving and handling. A record of completion is maintained on an electronic human resources system. Staff are trained and understand the practice of tikanga Māori. Staff also complete cultural safety training and are provided with opportunities to learn about Māori health outcomes, disparities, and health equity trends. The cultural training module equipped staff to be culturally competent to provide high quality care for Māori. Staff wellbeing is recognised through acknowledging individual staff contributions and participation in health and wellbeing activities. Staff interviewed report a positive supportive work environment.
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.	FA	There are human resources policies in place, including recruitment, selection, orientation, and staff training and development. Police checks are not routinely completed as per organisational human resources policy. Staff files are held securely. Six staff files were selected for review, which evidence recruitment processes are being implemented and includes reference checking, qualifications, and annual practising certificates. The service has an orientation programme in place that provides new staff with relevant information for safe work practice, and includes buddying with a more experienced staff member when first employed. Competencies are completed at orientation and then annually. The service demonstrates that the orientation programme supports all staff to provide a culturally safe environment for Māori. There was evidence of completed orientation documents on files. The service collects ethnicity data of employees and maintains an employee ethnicity database. There are job descriptions in place for all

		positions, which includes outcomes, accountability, responsibilities, authority, and functions to be achieved in each position. A register of current practising certificates is maintained for all health professionals. Schedules and processes are in place for annual appraisals. All staff files reviewed had a completed annual performance appraisal in place. Staff information is accurate, relevant, secure, and kept confidential. Staff wellbeing is supported, with evidence of debriefing occurring following incidents/accidents.
Subsection 2.5: Information The people: Service providers manage my information sensitively and in accordance with my wishes. Te Tiriti: Service providers collect, store, and use quality ethnicity data in order to achieve Māori health equity. As service provider: We ensure the collection, storage, and use of personal and health information of people using our services is accurate, sufficient, secure, accessible, and confidential.	FA	Resident files and the information associated with residents and staff are retained both electronically and in hard copy (kept in locked cabinets when not in use). Electronic information is regularly backed up and password protected. There is a documented emergency management plan in case of information systems failure. The resident files are appropriate to the service type and demonstrated service integration. Records are uniquely identifiable, legible, and timely. Signatures that are documented include the name and designation of the service provider. Residents archived files are securely stored off site and/or backed up on the electronic system and are easily retrievable when required. Other paper documents can be scanned and uploaded in the gallery in the electronic system for reference. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. The service is not responsible for National Health Index registration.
Subsection 3.1: Entry and declining entry The people: Service providers clearly communicate access, timeframes, and costs of accessing services, so that I can choose the most appropriate service provider to meet my needs. Te Tiriti: Service providers work proactively to eliminate inequities between Māori and non-Māori by ensuring fair access to quality	PA Low	There are policies in place for entry and decline processes. Residents' entry into the service is facilitated in a competent, equitable, timely and respectful manner. Information packs are provided for family/whānau prior to admission, or on entry to the service. Review of residents' files confirmed admission complied with entry criteria. The service admission agreement reviewed aligns with

care. As service providers: When people enter our service, we adopt a person-centred and whānau-centred approach to their care. We focus on their needs and goals and encourage input from whānau. Where we are unable to meet these needs, adequate information about the reasons for this decision is documented and communicated to the person and whānau.		all service requirements. Each of the seven resident files reviewed included a signed admission agreement, signed by the resident, or their enduring power of attorney (EPOA) or welfare guardian where these were in place and had been activated. Exclusions from the service are included in the admission agreement. Family/whānau interviewed stated they received the information pack, along with sufficient information prior to and on entry to the service, and they were invited to have a tour of the facility, and to meet staff prior to their loved ones' entry. Admission criteria are based on the assessed need of the residents, all of whom were assessed as requiring psychogeriatric level of care. The service openly communicates with prospective family/whānau during the admission process and keeps the referral agency and family/whānau informed, should there be a delay. Improvement is required in collecting and analysing ethnicity data to determine entry and decline rates for Māori. The facility manager stated to date they have not declined entry. Staff confirmed they work in partnership with Māori whānau to ensure their specific cultural needs are met during the entry process.
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	Seven resident files were reviewed, including one young person disabled (YPD). Registered nurses are responsible for conducting all assessments, and for the development and review of care plans. Family/whānau confirmed they are involved in assessment, care planning and review processes, and resident files show evidence of family/whānau involvement. Cultural assessments are completed for all residents by registered nurses. Māori residents have personal profiles and individual care plans that include cultural preferences, whānau involvement and tikanga considerations to ensure the service supports Māori and family/whānau to identify their own pae ora outcomes. This was evidenced in files of residents who identify as Māori. Residents who identify as Pasifika have a care plan in place that addresses their cultural preferences and needs. The clinical manager reported any barriers that prevent tāngata whaikaha and whānau from independently accessing information or services are identified, and

		strategies to manage these are documented. Staff confirmed they understood the process to support residents and family/whānau. All residents have admission assessment information collected and an initial care plan completed at the time of admission. All reviewed files (including the YPD resident) have up-to-date interRAI assessments completed. Resident files reviewed confirmed the initial interRAI assessments and initial and long-term care plans were completed in a timely manner and within the required timeframes. Improvement is required in the detail of interventions to manage all risks, early warning signs, and guide care delivery. The care plans are holistic and align with the service's model of person-centred care. Improvement is required in detailing behaviour management strategies to include prevention-based strategies for minimising episodes of challenging behaviours; and a description of how the behaviour is best managed over a 24-hour period. InterRAI assessments and care plan evaluations are completed at least six-monthly or when residents' needs changed. Evaluations document the progress towards the individual`s goals and if they are met or unmet. Short-term care plans for short-term needs, such as infections and wounds were well utilised, with interventions transferred to the long-term care plans in a timely manner. The service actively reviews the interRAI outcome scores for each resident and compares with the previous interRAI when reviewing care plans. The registered nurses use this tool to discuss if there are any other interventions that might be helpful, if interRAI scores have changed. A general practitioner ensures residents are assessed within five working days of admission. The general practitioner visits weekly and reviews each resident at least three-monthly. The general practice provides 24/7 on-call services. The general practitioner was interviewed and expressed no concerns with the competency of staff, but highlighted a lack of a full-time clinical manager to make sound clinical decisions. Specialist referrals are initiated as needed. Allied health interventions are documented and integrated into care plans. The service has an independent physiotherapist contracted to work as needed. A dietitian is contacted as required. A continence advisor,

		mental health team and wound nurse specialist are available as required. A podiatrist visits six-weekly. Caregivers and registered nurses interviewed described a verbal handover at the beginning of each duty that maintains a continuity of service delivery; this was observed on the day of audit and found to be comprehensive in nature. Progress notes are written at least daily by registered nurses and each shift by caregivers. The electronic progress notes detail any new events (infections and incidents as examples) and follow up for any interventions (wound dressings as an example). The registered nurses further add to the progress notes following general practitioner visits or changes in health status. Family/whānau interviewed expressed a high degree of satisfaction with the cares their loved ones receive, the staff and availability of management. When a resident's condition alters, the registered nurses initiate a review with the general practitioner. Family/whānau stated they are notified of all changes to health, including infections, accident/incidents, general practitioner visits, medication changes, and any changes to health status, and this was consistently documented in the resident's progress notes. A wound register is maintained. There was a total of 30 wounds for 13 residents, including skin tears and a chronic ulcer. There were no pressure injuries. A sample of wounds were reviewed. Improvement is required in assessment and management of wounds. Staff stated they could access the wound nurse specialist if needed. Caregivers and registered nurses confirmed there are adequate clinical supplies and equipment provided, including continence, wound care supplies, and pressure injury prevention resources. Caregivers and registered nurses complete monitoring charts, including bowel chart; vital signs; weight; food and fluid intake; pain; blood glucose levels; and restraint monitoring. Improvement is required in completing neurological observations as per the policy for unwitnessed falls, or where a head injury is suspected.
Subsection 3.3: Individualised activities The people: I participate in what matters to me in a way that I like. Te Tiriti: Service providers support Māori community initiatives and	PA Moderate	The activities programme is led by an activities coordinator who works five days per week. They are assisted by caregivers. There is another person employed to provide activities on weekends. The

activities that promote whanaungatanga. As service providers: We support the people using our services to maintain and develop their interests and participate in meaningful community and social activities, planned and unplanned, which are suitable for their age and stage and are satisfying to them.		activities programme consists of exercises, ball, and balloon games, singing, church services weekly, television, music, videos, and van outings in the summer. A Malaysian singing group visit weekly. For those who don't want to participate in group activities, one-on-one session are provided and include conversations and individual exercises. No specific activities are recorded on the programme for residents with behaviours that challenge, or who have sensory impairment. Individual interests and preferences are identified by the registered nurse in collaboration with family/whānau and entered in the long-term care plan. During the audit, residents were observed to be participating in the exercises. Residents' visitors are welcomed into the facility, and some are visited daily by friends and family/whānau. Calendar events including Matariki, Waitangi Day, Christmas, Easter, and Chinese New Year (as examples) are celebrated. Māori and Pacific residents participate in waiata.
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	A medication management policy is implemented for safe medicine management, and this meets legislative requirements. All staff who administer medications are assessed for competency on an annual basis. Education around safe medication administration has been provided. Registered nurses have not completed syringe driver training (link 2.3.3). Staff were observed to be safely administering medications. Registered nurses and caregivers interviewed could describe their role regarding medication administration. The facility uses robotic rolls. All medications are checked on delivery against the medication chart, and any discrepancies are fed back to the supplying pharmacy. Unused and expired medications are returned to the pharmacy. Medications were stored securely. There is one medication room. Medication trolleys were observed to be locked when not in use. The medication refrigerator is monitored daily and is maintained within an acceptable range. The room temperature in the medication room is

		monitored daily and maintained within an acceptable range. Improvement is required in checking the expiry dates of stored medication. All eyedrops have been dated on opening and discarded as per manufacturer's instructions. All over the counter vitamins, supplements or alternative therapies residents use are prescribed by the general practitioner and charted on the electronic medication chart. Fourteen electronic medication charts were reviewed. The medication charts reviewed confirmed the general practitioner reviews all resident medication charts at least three-monthly, and each chart has photo identification and allergy status identified. There are no residents self-administering their medications. Pro re nata medication is administered as prescribed, and effectiveness is documented on the electronic medication system or in the progress notes. Medication competent caregivers or registered nurses sign when the medication has been administered. There are no vaccines kept on site. There are standing orders. The general practitioner has signed the standing order authority in February 2025. The standing orders specify the medication, dose, and indications. Family/whānau are updated around medication changes, including the reason for changing medications and potential adverse reactions. This is documented in the progress notes. The clinical nurse leader described the process to work in partnership with Māori residents and family/whānau to ensure the appropriate support is in place, advice is timely, easily accessed, and treatment is prioritised to achieve better health outcomes. Residents and their family/ whānau are supported 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	PA Low	All meals are prepared and cooked on site. There is one main cook and a kitchen assistant. All kitchen staff have completed safe food handling. The kitchen was observed to be clean, well-organised, well equipped and a current approved food control plan was in place, expiring on 31 March 2026. However, there is no documented cleaning schedule

needs are met to promote and maintain their health and wellbeing.		that is signed off and monitored (link 5.5.3). A registered dietitian has reviewed the four-weekly seasonal menu. Improvement is required in ensuring the correct seasonal menu is used. If residents do not like what is on the menu, they are offered an alternative. There is a food services manual available in the kitchen. The cook receives resident dietary information from the registered nurses and is notified of any changes to dietary requirements (vegetarian, diabetic, pureed foods) or residents with weight loss. Nutritional supplements are prescribed by the general practitioner and provided as prescribed. The cook confirmed they are aware of resident likes, dislikes, and special dietary requirements. A whiteboard on the wall of the kitchen summarises residents' special dietary requirements. Alternative meals are offered for those residents with dislikes, or religious and cultural preferences. Māori or Pasifika menu options are available upon request and family/whānau can bring special meals for their loved ones. Residents have access to nutritious snacks 24/7. On the day of audit, meals were observed to be well presented. Kitchen staff check fridge and freezer temperature daily and records show these are maintained within an acceptable range. Food temperatures are checked at different stages of the preparation process. These are all within safe limits. Staff were observed wearing correct personal protective clothing in the kitchen. Meals are served directly from the kitchen to the adjoining dining room. Residents were observed enjoying their meals. Staff were observed assisting residents with meals in the dining room. Modified utensils are available for residents to maintain independence with eating as required. Family/whānau can offer feedback on the food service through family/whānau surveys.
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	FA	Policies and procedures outline the process and required documentation for transfer and discharge, including transfer to a different level of care. Discharge and transfer are planned processes that are communicated with family/whānau. Family/whānau are

wellbeing when I leave the service. Te Tiriti: Service providers advocate for Māori to ensure they and whānau receive the necessary support during their transition, transfer, and discharge. As service providers: We ensure the people using our service experience consistency and continuity when leaving our services. We work alongside each person and whānau to provide and coordinate a supported transition of care or support.		advised of the reason for transition/transfer, options to access other health and disability services, social support or Kaupapa Māori agencies if indicated or requested. To coordinate a supported transition of care when residents are transferred to the public hospital, the registered nurse completes a set of transfer documents, the family/whānau is informed, and the general practitioner makes the referral to hospital. Relevant documentation sent with the resident includes a printout of their current medications, care needs, and a copy of enduring power of attorney/welfare guardian documents. Resident needs and potential risks are communicated to the health service by the registered nurse. Where resident's wish or need to be seen by another health service, referral is made. Residents attending external appointments are encouraged to be accompanied by their family/whānau.
Subsection 4.1: The facility The people: I feel the environment is designed in a way that is safe and is sensitive to my needs. I am able to enter, exit, and move around the environment freely and safely. Te Tiriti: The environment and setting are designed to be Māori-centred and culturally safe for Māori and whānau. As service providers: Our physical environment is safe, well maintained, tidy, and comfortable and accessible, and the people we deliver services to can move independently and freely throughout. The physical environment optimises people's sense of belonging, independence, interaction, and function.	PA Moderate	The building warrant of fitness is current to 19 October 2026. The facility manager is responsible for maintenance. Compliance for the building warrant of fitness is contracted out. The annual preventative maintenance schedule is implemented by the facility manager. Once tasks are completed, they are signed off. Staff can request repairs and maintenance in a maintenance logbook. This is checked daily by the facility manager and signed off when jobs are completed. For urgent repairs, staff call the facility manager, who can access essential contractors, such as plumbers and electricians at any time. The facility is on one level. Access to the building is by electronic pass code. There are heat pumps for temperature control. Fixtures, fittings, and flooring are appropriate. Electrical testing and tagging of all appliances was completed on 30 January 2025. Clinical equipment was last checked and calibrated in February 2025. Hot water temperatures are checked monthly in each area, and records show a safe temperature is maintained. All hand-washing areas have free flowing soap and paper towels in the toilet areas, sluice room, medication room, and kitchen. There is one main lounge and several smaller lounges situated throughout the facility. There is one main dining room adjacent to the

		kitchen. There is ample room for residents to walk freely and safely. There are two decked areas that residents can access freely. There are two further outdoor areas that residents cannot freely access as the doors are kept locked. Family/whānau interviewed expressed they would prefer their loved one could sit outside when they wanted to. Throughout the facility there are handrails in bathrooms and hallways. All rooms and communal areas allow for safe use of mobility equipment. There is adequate space for storage of mobility equipment. Furniture is appropriate for residents. Activities are provided in the main lounge. The resident rooms are of sufficient size to meet the residents' assessed needs. Residents are able to manoeuvre mobility aids around the bed and personal space. Resident rooms were seen to have personal items of significance displayed. Not all resident rooms have an external window. There are enough toilets in communal areas for residents and separate toilets for staff and visitors. Toilets have privacy systems in place. The facility manager and owner/manager expressed their awareness of the need to consult the community to ensure the facility meets the needs and aspirations of Māori, should there be any changes to the building.
Subsection 4.2: Security of people and workforce The people: I trust that if there is an emergency, my service provider will ensure I am safe. Te Tiriti: Service providers provide quality information on emergency and security arrangements to Māori and whānau. As service providers: We deliver care and support in a planned and safe way, including during an emergency or unexpected event.	PA Low	Policies and procedures for fire safety, emergency planning, preparation, and response are available and known to staff. Civil defence planning guides direct the facility in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency. A fire evacuation plan is in place and was approved by Fire and Emergency New Zealand on 2 March 2018. Fire evacuation drills are conducted every six months, and these are added to the training programme. The latest evacuation drill was completed on 3 July 2025, and a record of attendance was sighted.

		The staff orientation programme includes fire and security training. Fire exit doors were clearly labelled and free from clutter. All required fire equipment is checked within the required timeframes by an external contractor. A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency, including food, water (4000 litre tank of potable water) and continence products. Improvement is required in having a suitable plan in place in the event of a power outage. All registered nurses and some caregivers have current first aid certificates. There is always at least one staff member on duty with a current first aid certificate. Staff demonstrated their understanding of emergency procedures. Call bells were sighted in each bedroom, communal areas and in toilet/shower areas. These are checked monthly by the facility manager and records are entered into the maintenance folder. Family/whānau confirmed staff respond to call bells promptly. Appropriate security arrangements are in place. Access to and exit from the building is by electronic passcode. Staff are required to ensure all windows are locked at night. There are closed circuit television cameras operating in the grounds and communal areas including hallways. Emergency procedures are explained to family/whānau upon admission to services. Family/whānau confirmed they know the process of alerting staff when in need of access to the facility after hours. The visitors' policy and guidelines were available to ensure resident safety and wellbeing are not compromised by visitors to the service.
Subsection 5.1: Governance The people: I trust the service provider shows competent leadership to manage my risk of infection and use antimicrobials appropriately. Te Tiriti: Monitoring of equity for Māori is an important component of IP and AMS programme governance. As service providers: Our governance is accountable for ensuring the IP and AMS needs of our service are being met, and we participate in national and regional IP and AMS programmes and	FA	Infection prevention and control and antimicrobial stewardship (AMS) is an integral part of the services’ quality and risk management plan to ensure an environment that minimises the risk of infection to residents, staff, and visitors. Infection prevention and control, and AMS resources are accessible. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. Infection control is linked into the quality risk and incident reporting system. The infection prevention and AMS programmes

respond to relevant issues of national and regional concern.		have been approved by the owner/manager and are reviewed and reported on yearly (last completed 20 December 2025). Monthly staff meetings include discussions regarding any residents of concerns, including any infections. Infection rates are presented and discussed. The data is summarised and analysed for trends and patterns. The owner/manager and management team attend the staff meetings and are informed of urgent or significant issues immediately. The infection control coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections. Additional support and information are accessed from the infection control team at Health New Zealand, the community laboratory, and the general practitioner as required.
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.	PA Moderate	The service has a documented infection prevention and control programme that is reviewed annually. The external consultant, the clinical manager and the owner/manager complete the review. The infection control coordinator, a registered nurse, oversees and coordinates the implementation of the infection control programme. The infection control coordinator's role, responsibilities and reporting requirements are defined in the infection control coordinator's job description. On interview, the infection control coordinator reported they have support from other members of staff and the management team regarding infection prevention matters. This includes time, resources, and training. The service has a pandemic plan and guidelines to manage and prevent exposure to infections. Infection prevention and control training is provided to staff, residents, and visitors. Although there was sufficient PPE to manage day to day use, the service did not have adequate supplies of personal protective equipment (PPE), and hand sanitisers in stock in the event of an outbreak. Hand-washing audits were completed as per schedule. Staff are advised not to attend work if they are unwell, or self-isolate and get tested if they have been in contact with a person who has tested positive for Covid-19. Information and resources to support staff in

		managing Covid-19 and other infections were regularly updated. The service has documented policies and procedures that reflect current best practices. These policies and procedures are accessible and available for staff at the service. Care delivery, cleaning, laundry, and kitchen processes were reviewed and observed. Staff were observed following organisational policies, such as appropriate use of hand sanitisers, good hand-washing techniques, and use of disposable aprons and gloves. Staff demonstrated knowledge of the requirements of standard precautions and were able to locate policies and procedures. Staff training on infection prevention and control is provided during orientation and two-yearly in-service education. The training includes handwashing procedures, donning and doffing of personal protective equipment, and regular Covid-19 updates. Records of staff education were maintained. The infection control coordinator has completed external education on infection prevention and control for clinical staff (in January 2026). The infection control coordinator reported they are supported by the management team and owner/manager in procurement processes for equipment, devices, and consumables. The facility manager, clinical manager, and infection control coordinator reported that there were processes in place for early consultation with the infection prevention personnel in the event of any new building. In an interview conducted, the infection control coordinator reported that single-use medical devices are not re-used at the service. Policies and procedures are in place regarding reusable and single-use equipment; however, these were not implemented for reusable equipment and shared equipment is not appropriately disinfected between uses (link 5.5.3). There is a documented internal auditing process to monitor this. The service has printed infection prevention educational resources in te reo Māori. Kindred Hospital works in partnership with Māori for the protection of culturally safe practices in infection prevention, acknowledging the spirit of Te Tiriti. In interviews, staff understood these requirements.

Subsection 5.3: Antimicrobial stewardship (AMS) programme and implementation The people: I trust that my service provider is committed to 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.	FA	The antimicrobial stewardship (AMS) programme was approved by the owner/manager in consultation with an external consultant. The antimicrobial policy is appropriate for the resident cohort's size, scope, and complexity. The policy aims to promote optimal management of antimicrobials to maximise the effectiveness of treatment and minimise potential for harm. Responsible use of antimicrobials is promoted. The general practitioner has overall responsibility for antimicrobial prescribing. Monthly records of infections and prescribed treatment were maintained. Antimicrobial stewardship data is being collected. Reports are completed monthly and annually, and these are discussed at staff meetings. These provide a summary along with any relevant issues for consideration by the owner/manager, management, and staff. The infection control coordinator has access to all relevant residents' data to undertake surveillance, internal audits, and investigations, including any occurrences of adverse effects. Staff confirmed that infection rates information is shared in a timely manner.
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.	PA Low	The infection surveillance programme is appropriate for the size and complexity of the service. Infection data is collected, monitored, and reviewed monthly. The data is collated, and action plans are implemented. The healthcare associated infections being monitored include infections of the urinary tract, skin, eyes, respiratory, and wounds. Surveillance tools are used to collect infection data and standardised surveillance definitions are used. Staff reported that they are informed of infection rates and regular audit outcomes at meetings. Results are reported to management and the owner/manager. Records of monthly data sighted identified numbers of infections, comparison with the previous month, reason for increase or decrease, and action taken (as indicated). Any new infections are discussed at shift handovers for early interventions to be implemented. Surveillance of healthcare-associated infections includes ethnicity data, and the data is reported to staff,

		management, and the owner/manager. Family/whānau are advised of any infections identified in a culturally safe manner. This was confirmed in progress notes sampled and verified in interviews with family/whānau. There has been one outbreak reported since last audit (Covid-19 in July 2025). There is no documented evidence to demonstrate how the outbreak was managed, including appropriate communication and notification to relevant authorities.
Subsection 5.5: Environment The people: I trust health care and support workers to maintain a hygienic environment. My feedback is sought on cleanliness within the environment. Te Tiriti: Māori are assured that culturally safe and appropriate decisions are made in relation to infection prevention and environment. Communication about the environment is culturally safe and easily accessible. As service providers: We deliver services in a clean, hygienic environment that facilitates the prevention of infection and transmission of antimicrobialresistant organisms.	PA Moderate	There are documented processes for the management of waste and hazardous substances. Domestic waste is removed as per local authority requirements. All chemicals were observed to be stored securely and safely. Material data safety sheets were displayed in the sluice room/cleaning/chemical room. Cleaning products were in labelled bottles. There are designated staff for cleaning services. The cleaners ensure that trolleys are safely stored when not in use. PPE was available which includes masks, gloves, goggles, and aprons for day-to-day use by staff. Staff demonstrated knowledge on donning and doffing of PPE. Cleaning guidelines were not evident at the time of the audit. Cleaning equipment and supplies were stored safely in locked sluice room when not in use. Cleaning schedules were not maintained for daily and periodic cleaning, as well as communally used equipment. The facility was observed to be clean on the days of the audit. Staff have not completed training appropriate to their roles including chemical safety (link 2.3.4). The facility manager and infection control coordinator have oversight of the home testing and monitoring programme for the built environment. There are regular internal environmental cleanliness audits completed. All the laundry is completed off site at the sister facility, except for kitchen related linen, which is completed in a domestic washing machine on site. Dirty laundry is sorted into leak proof laundry bags that are stored in the sluice room for daily collection by a designated staff, who delivers it to the sister facility. Clean laundry is delivered daily into a designated clean room for sorting and delivery back to the residents by caregivers each day.

		There is one designated sluice room which is not clearly separated into clean and dirty areas. Staff have received training regarding laundry processes at orientation, and documented laundry process guidelines are available. The effectiveness of laundry processes is monitored by the internal audit programme. The caregivers interviewed demonstrated awareness of the infection prevention and control protocols. Satisfaction surveys and interviews with family/whānau confirmed satisfaction with the cleaning and laundry processes. Corrective actions from cleaning and laundry audits are identified and implemented. Results are discussed at all meetings.
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 policy and procedures for restraint minimisation and safe practice specify Kindred Hospital is committed to providing a restraint-free environment to the best of their ability. This is supported by the owner/manager, facility manager, clinical manager and staff. The policy and procedures have been developed by a consultant who is well known in the aged care sector and approved by the owner/manager. The policy requires when restraint is considered, the facility works in partnership with Māori, to ensure resident voices are heard, and ensure services are mana enhancing. During the audit there were ten residents using restraints, either lap belts and/or bedrails. The service is committed to reducing the use of restraint by 50% over 2026. The restraint coordinator is a registered nurse. A job description is in place for the restraint coordinator role. The restraint coordinator stated their commitment to least restrictive practices is through ensuring residents needs are met through intentional rounding, regular toileting, implementing falls prevention strategies, use of equipment such as sensor mats and landing mattresses as examples, effective communication with family/whānau, and educating staff on maintaining safety for individual residents. The restraint committee is comprised of the restraint coordinator, the clinical manager and general practitioner. Restraint use is reported at the monthly staff meetings. The restraint coordinator reports on

		restraint use to the owner/manager. Training records demonstrate staff receive education on the restraint minimisation policy and procedures during orientation. Thereafter staff receive annual education on restraint minimisation, management of challenging behaviour, and de-escalation. Staff complete an annual competency test.
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	Interview with the restraint coordinator and review of four residents' files who use restraint show restraints are required to be approved by the restraint coordinator and general practitioner in consultation with family/whānau. Before approving a restraint, the service ensures all alternatives have been exhausted, including use of extra low beds, landing mattresses, sensor mats, intentional rounding, and other falls prevention strategies. An assessment is completed first which includes the resident's previous experience with restraint, if there is an underlying infection (which is treated before applying restraint), any risks to the resident, potential benefits, cultural needs, and monitoring requirements. The restraint coordinator determines the frequency and extent of monitoring which is based on the resident's needs and risks. Improvement is required in detailing the monitoring requirements in the long-term care plan including cultural, physical, psychological, psychosocial needs and the residents' wairuatanga. Monitoring records show residents are monitored two-hourly, but improvement is required in documenting the detail of what was monitored. The restraint coordinator maintains a restraint register which includes the following: name of the resident; type of restraint; reason for initiating restraint; alternatives tried; family/whānau support; outcome of the restraint (such as no falls); any adverse events related to the restraint; observations and monitoring; and evaluation (six-monthly). There is a procedure included in the restraint minimisation and safe practice policy for emergency restraint. The restraint coordinator stated emergency restraint has not been used since the facility opened. The emergency restraint procedure includes a requirement

		for debriefing. The six-monthly evaluations are discussed with the restraint coordinator, clinical manager, clinical nurse leader and general practitioner, and with individual family/whānau include: the type of restraint used and whether this can be discontinued or modified (such as using one bed rail instead of two); whether the care plan details the interventions and support required and whether these were implemented; the impact of restraint to the resident, family/whānau and staff; whether the time using restraint was the least amount possible; what other alternatives are used and the effectiveness of these; the ongoing support and advocacy for the resident; whether monitoring is sufficient and effective; and other options that could be tried as an alternative. Staff meetings provide a forum for staff to discuss restraint.
Subsection 6.3: Quality review of restraint The people: I feel safe to share my experiences of restraint so I can influence least restrictive practice. Te Tiriti: Monitoring and quality review focus on a commitment to reducing inequities in the rate of restrictive practices experienced by Māori and implementing solutions. As service providers: We maintain or are working towards a restraint-free environment by collecting, monitoring, and reviewing data and implementing improvement activities.	PA Moderate	The policy includes a requirement to undertake six-monthly quality review of restraint. Individual evaluation of restraint is conducted six-monthly. Improvement is required in overall quality review of restraint.

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 is a documented complaints policy which meets the guidelines as set by the Health and Disability Commissioner (HDC). The clinical manager has responsibility for ensuring all complaints (verbal and written) are fully documented and investigated. However, review of the complaints register did not evidence the anonymous complaint received by Health NZ, which Health NZ followed up with the service in July 2025. Interview with one family/whānau at the time of the audit confirmed that they had submitted a written complaint to staff, that staff acknowledged; however, this was not documented on the register	(i)There is no evidence that all complaints received have been logged on the complaints register. (ii)There is no documented evidence of quality improvement and/or corrective action plan in line with one external complaint received in July 2025.	(i)Ensure all complaints are logged on the complaints register as per policy. (ii)Ensure that quality improvement and/or corrective action plan are completed and implemented as per policy following complaints. 60 days

		reviewed. There was no documented quality improvement and/or corrective action plan as per policy to evidence follow-up completed related to the anonymous complaint that was discussed by Health NZ with the service in July 2025.		
Criterion 2.1.3 Governance bodies shall appoint a suitably qualified or experienced person to manage the service provider with authority, accountability, and responsibility for service provision.	PA Moderate	The day-to-day operations are overseen by the facility manager (non-clinical) who has been in the role since the facility opened in 2023. They are supported by a clinical manager, a registered nurse with a current practicing certificate. The facility manager and clinical manager provide oversight of the two sister facilities. The status of the clinical manager role has not changed since last audit. They continue to work across the two facilities, two days for each and a third day split, depending on which facility has a clinical oversight need. At the time of the audit the service had appointed a clinical nurse leader (with a plan to take over from the clinical manager). The roster beginning 5 January 2026 shows the start of the clinical lead rostered from 0800 to 1630. However, there is no other	The oversight of the day-to-day operations of Kindred Hospital do not meet the contractual requirements of the Aged Residential Hospital Specialised Services (ARHSS) agreement Clause D17.5 criteria for manager. Ongoing from the last audit, the service has not demonstrated that there is sufficient time allocated to the clinical manager for them to provide clinical oversight, monitoring of quality and risk management systems, education for staff, and hands on role modelling at Kindred Hospital.	Ensure appointment of a suitably qualified or experienced person into full time position to manage Kindred Hospital with authority, accountability, and responsibility for clinical services, and who meets the contractual requirements of the Aged Residential Hospital Specialised Services agreement Clause D17.5 criteria. 30 days

		registered nurse added to the roster, hence the clinical lead continues to be the second registered nurse on duty, thus not allowing them time to provide the clinical oversight. In addition, review of the qualifications and experience of the clinical nurse leader did not demonstrate compliance with Aged Residential Hospital Specialised Services agreement Clause D17.5 criteria.		
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	A quality and risk management programme is documented. The quality and risk management systems include performance monitoring through internal audits and through the collection of clinical indicator data. Incident and accident data is collated monthly and analysed. The data is discussed in the monthly staff meetings. Kindred Hospital has however not collated and analysed quality data annually as per policy to demonstrate risk-based approach and critical review to improve service delivery. This was evident for year end 2024 and year end 2025.	The annual collation and analysis of incident and accidents have not been completed for 2024 and 2025 as per policy to demonstrate risk-based approach / critical review to improve service delivery.	Ensure critical review and analysis of accident and incidents using a risk-based approach as per policy to improve service delivery. 60 days
Criterion 2.2.5 Service providers shall follow	PA Moderate	Kindred Hospital enters all incidents and accidents in the	(i)Four incidents related to episodes of resident physical	(i)Ensure that incident and accident reports are completed for all

the National Adverse Event Reporting Policy for internal and external reporting (where required) to reduce preventable harm by supporting systems learnings.		electronic resident management system. However, electronic entries have not been completed for each incident/accident. At the time of the audit, incidents related to resident behaviours where there was physical altercation involving another resident or staff did not have a corresponding incident and evidence of follow-up of the other party. Two separate medication incidents that were reviewed where residents had received other resident's medication did not show robust follow-up processes that take a risk-based approach to reduce preventable harm. This included (but not limited to) lack of notification and involvement of the general practitioner, ongoing resident monitoring of vital signs and effects of the medications, and follow-up with staff members involved. Incidents and accidents are discussed in the staff meetings and at handover.	aggression to other residents / staff do not have a corresponding incident report completed for the other resident / staff. (ii)Two medication related incidents did not demonstrate robust follow-up and corrective actions to reduce preventable harm.	residents and staff involved and affected. (ii)Ensure that robust follow-up of incidents and accidents to reduce preventable harm. 90 days
Criterion 2.3.2 Service providers shall ensure their health care and support workers have the skills, attitudes, qualifications, experience, and attributes for the	PA Moderate	At the time of the audit, six caregivers were yet to complete the psychogeriatric unit standards. The six caregivers were past the 18-month period as per the ARHSS agreement D17.11c. This is a continued partial attainment finding from the	(i)The service continues to have six caregivers that have not completed the required psychogeriatric unit standards as per the requirements of ARHSS agreement D17.11c. (ii)At the time of the audit, the	(i)Ensure that staff complete the required psychogeriatric unit standards as per the requirements of ARHSS agreement D17.11c. (ii)Ensure that the service employs an activity coordinator meeting the requirements of ARHSS agreement

services being delivered.		last audit completed in January 2025. The service employs an activity coordinator who works full time to facilitate the activity programme. However, review of their experience and qualifications demonstrates that they do not meet the requirements as per ARHSS agreement D17.7.	activity coordinator did not have the role requirements in line with the ARHSS agreement D17.7.	D17.7 30 days
Criterion 2.3.3 Service providers shall implement systems to determine and develop the competencies of health care and support workers to meet the needs of people equitably.	PA Moderate	There is a range of competencies specific to the employee's role with a schedule and register in place. For registered nurses this includes (but not limited to) competencies related to medicine management, syringe driver, first aid and CPR, moving and handling, and restraint. At the time of the audit, the service did not have any registered nurses who had completed syringe driver training and competency.	There are no registered nurses that have completed syringe driver training and competency.	Ensure that the service has registered nurses who have completed syringe driver training and competency to meet the needs of the residents. 60 days
Criterion 2.3.4 Service providers shall ensure there is a system to identify, plan, facilitate, and record ongoing learning and development for health care and support workers so that they can provide high-quality safe services.	PA Low	There is a two-yearly education and training schedule that has not been fully implemented to date. Review of the training schedule and topics that have been completed demonstrates that the service has completed training related to challenging behaviour; prevention and understanding dementia; continence; infection	The two-yearly mandatory training schedule has not been completed as per policy.	Ensure that training is completed as per policy. 60 days

		control; cultural safety and competency; detection and prevention of dehydration; and health and safety over the two-year period. However, there is no evidence of training related to abuse and neglect; pain; resident rights; sexuality and intimacy; quality and risk exceptional reporting; pressure injury; activities; and chemical safety as per policy requirements.		
Criterion 3.1.5 Service providers demonstrate routine analysis to show entry and decline rates. This must include specific data for entry and decline rates for Māori.	PA Low	The facility manager stated to date they have not declined entry. Data is collected for those enquiring, including the Needs Assessment Coordination Service (NASC) assessment for psychogeriatric level of care and resident demographics.	Ethnicity information is not collected upon enquiry into the service, so entry and decline analysis for Māori cannot be completed.	Collect ethnicity information and analyse entry and decline rates by ethnicity. 180 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	PA Moderate	Care plans are developed by registered nurses in collaboration with family/whānau. Assessment is a comprehensive process that includes cultural needs and preferences and residents' previous life experiences. Residents who identify as Māori or Pasifika have care plans in place that document their specific cultural needs. There is evidence of family/whānau involvement in cultural assessments and care	(i)There is insufficient detail in long-term care plans to direct staff in meeting the needs of residents where the interRAI assessment has triggered a risk, such as falls risk, pressure injury risk, mood, behaviour, and undernutrition. (ii)24-hour behaviour management plans are not developed to guide staff in managing residents over the	(i)Ensure long-term care plans are detailed to direct staff in all required interventions to meet the needs of residents. (ii)Ensure care plans include behaviour management plans that guide staff in managing residents over the 24-hour period. (iii)Complete neurological observations as per the policy following unwitnessed falls.

assessment includes consideration of people's lived experience; (d) Cultural needs, values, and beliefs are considered; (e) Cultural assessments are completed by culturally competent workers and are accessible in all settings and circumstances. This includes traditional healing practitioners as well as rākau rongoā, mirimiri, and karakia; (f) Strengths, goals, and aspirations are described and align with people's values and beliefs. The support required to achieve these is clearly documented and communicated; (g) Early warning signs and risks that may adversely affect a person's wellbeing are recorded, with a focus on prevention or escalation for appropriate intervention; (h) People's care or support plan identifies wider service integration as required.		plans.	24-hour period. (iii)Neurological observations following unwitnessed falls were not completed according to the policy in four of four records of unwitnessed falls reviewed.	90 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	PA Moderate	Resident files evidence at least six-monthly review in collaboration with family/whānau. Staff utilise interRAI outcomes to assess if interventions are meeting the needs of residents. Each goal of the care plan is	(i)Review of four of ten wound care plans and assessments showed a deterioration in wounds, with no change in the management of the wound. (ii)Wound assessments do not include photographs taken at	(i)Where progress of wounds is not as expected, ensure the management plan is reviewed and adjusted. (ii)Take regular photographs of wounds to assist in evaluating the

providers; (b) Include the use of a range of outcome measurements; (c) Record the degree of achievement against the person's agreed goals and aspiration as well as whānau goals and aspirations; (d) Identify changes to the person's care or support plan, which are agreed collaboratively through the ongoing re-assessment and review process, and ensure changes are implemented; (e) Ensure that, where progress is different from expected, the service provider in collaboration with the person receiving services and whānau responds by initiating changes to the care or support plan.		reviewed and adjusted where the needs of residents are changed. Where a resident's health status is different from expected, a review by the general practitioner is initiated.	regular intervals to assist with evaluation of the progress in all ten wound assessments reviewed.	progress. 90 days
Criterion 3.3.1 Meaningful activities shall be planned and facilitated to develop and enhance people's strengths, skills, resources, and interests, and shall be responsive to their identity.	PA Moderate	The activities programme includes daily exercises, a range of group games, music, singing and entertainment. Individual activities are provided for those that don't participate in group activities.	The activities programme was not specific for residents in psychogeriatric hospital care, with a lack of sensory activities and activities to calm residents who display agitated behaviours.	Ensure the activities programme is tailored specifically for residents in psychogeriatric hospital care. 90 days
Criterion 3.4.1 A medication management	PA Moderate	There is a medication management policy that meets	Monthly stocktake including checking of expiry dates of	Ensure monthly stocktakes are completed as per the policy.

system shall be implemented appropriate to the scope of the service.		current legislative requirements. Staff administering medications are required to be assessed as competent on an annual basis. A medication round was observed and seen to be safe. Staff could describe their responsibilities for receiving and storing of medication and returning unused and expired medications to the pharmacy.	stocked medications was not complete.	90 days
Criterion 3.5.4 The nutritional value of menus shall be reviewed by appropriately qualified personnel such as dietitians.	PA Low	A registered dietitian has reviewed the winter and summer menus. However, the summer menu was not in use at the time of audit.	The summer menu was not in use at the time of the audit.	Ensure the correct seasonal menu is provided. 180 days
Criterion 4.1.2 The physical environment, internal and external, shall be safe and accessible, minimise risk of harm, and promote safe mobility and independence.	PA Moderate	Hallways, lounges, and the dining room are spacious and allow safe mobility with the use of mobility aids. Handrails are in hallways and bathrooms to promote safety. There are two decks which resident can access. There are two further outdoor areas. One of these has recently been developed specifically for residents who wander, with a circular path and shaded seating area. Access to this outdoor area is by electronic passcode.	The main outdoor area is not accessible to residents.	Ensure residents can freely access outdoor areas. 90 days

Criterion 4.1.6 Each person's room shall have at least one external window, providing natural light, and appropriate ventilation and heating.	PA Moderate	Most rooms have an external window providing natural light and ventilation.	Five resident rooms (numbers 19, 20, 22, 24 and 28) do not have an external window, but have a window to either a corridor or another room.	Ensure all resident rooms have an external window. 90 days
Criterion 4.2.7 Alternative essential energy and utility sources shall be available, in the event of the main supplies failing.	PA Low	There are emergency supplies of food, water, continence products, and a civil defence bin that is checked three-monthly.	There is no contingency plan in place in the event of a power outage for supply of a generator.	Ensure there is a formal agreement in place for the supply of a generator in the event of a power outage. 180 days
Criterion 5.2.4 Service providers shall ensure that there is a pandemic or infectious disease response plan in place, that it is tested at regular intervals, and that there are sufficient IP resources including personal protective equipment (PPE) available or readily accessible to support this plan if it is activated.	PA Moderate	The service has a pandemic plan and guidelines to manage and prevent exposure to infections. Review of stock supplies of personal protective equipment (PPE) showed that the service did not have adequate supplies to use in case of an outbreak or emergency for at least three days. The outbreak box reviewed had one box of gloves, two boxes of RAT tests, one packet of blue gowns, one packet of yellow gowns, one box of masks, barrier cream and one alcogel. There were no yellow biohazard bags or linen bags for use in an outbreak. On the days of audit staff were observed following organisational policies, such as appropriate use of hand sanitisers, good hand-washing techniques, and use of disposable aprons and gloves.	At the time of the audit, there were no sufficient PPE resources in stock to ensure safe and effective management of an outbreak.	Ensure that there are adequate supplies of PPE in stock to ensure safe and effective management of an outbreak. 60 days

		Staff demonstrated knowledge of the requirements of standard precautions and were able to locate policies and procedures.		
Criterion 5.4.3 Surveillance methods, tools, documentation, analysis, and assignment of responsibilities shall be described and documented using standardised surveillance definitions. Surveillance includes ethnicity data.	PA Low	There are documented policies and processes related to management of outbreaks including Covid-19. In July 2025, the service had a Covid-19 outbreak that affected twelve residents and nine staff. However, there is no documented evidence as per policy to demonstrate that the outbreak processes were followed. This includes completion of outbreak logs, outbreak reports, essential notifications and debrief. Review of the meeting minutes for August 2025 identified that the facility had staff and residents affected by Covid-19 in the previous month.	There is no documented evidence to show implementation of the outbreak management process in relation to the July 2025 Covid-19 outbreak.	Ensure implementation of the outbreak process for identified outbreaks, including notification to relevant authorities. 90 days
Criterion 5.5.3 Service providers shall ensure that the environment is clean and there are safe and effective cleaning processes appropriate to the size and scope of the health and disability service that shall include:	PA Moderate	The service has one designated sluice which also serves as a cleaner's room and used for storage of chemicals. Observation and interview with staff on the day of the audit demonstrated that there was no clear separation of clean and dirty areas to minimise the risk of cross contamination. In the sluice	(i)There is no clear separation of clean and dirty areas in the sluice room to minimise the risk of cross contamination. (ii)There are no clearly documented processes for disinfection / sterilisation of communally used equipment. (iii)There is insufficient evidence	(i)Ensure that there is clear identification of clean and dirty areas in the sluice room to minimise risk of cross contamination. (ii)Ensure there are processes in place for sterilisation/disinfection of communally used equipment. (iii)Ensure cleaning practices meet

(a) Methods, frequency, and materials used for cleaning processes; (b) Cleaning processes that are monitored for effectiveness and audit, and feedback on performance is provided to the cleaning team; (c) Access to designated areas for the safe and hygienic storage of cleaning equipment and chemicals. This shall be reflected in a written policy.		room, there were communally used urinals that were discoloured with sediments. Interview with staff, observation and review of documents did not evidence that there are processes in place for sterilisation / disinfection of communally used equipment. At the time of the audit, observation and interview with the cleaning staff confirmed that there was use of same cloths from one resident room to the next for dusting of surface and hand basins. There are clearly documented policies to guide staff with cleaning that minimises the risk of spread of infection; however, the colour coding process for cleaning cloths and mop heads was not being implemented. There were no documented schedules to provide staff with guidance related to tasks to be completed for daily and periodic cleaning. The environment was observed to be clean on the days of the audit.	to show that the cleaning practices meet accepted infection control processes to minimise cross contamination between residents' rooms and communal toilets and showers. (iv)There are no colour coding process being implemented with cleaning cloths and mop heads as per policy. (v)There are no documented tasks to be completed for daily and periodic cleaning. (vi) There was no documented cleaning schedule in the kitchen and no records of cleaning having been completed.	accepted infection control processes. (iv)Ensure implementation of the cleaning policy. (v)Ensure there are documented processes for daily and periodic cleaning. (vi) Ensure there is a documented cleaning schedule in the kitchen, with sign off by staff when tasks are completed. 60 days
Criterion 6.2.3 Monitoring restraint shall include people's cultural, physical, psychological, and	PA Moderate	Long-term care plans identify residents are to be monitored at least two-hourly and this is to be recorded in the electronic	Care plans and monitoring records did not include all aspects staff were to monitor, including cultural, physical, psychosocial, psychological and	Ensure care plans are sufficiently detailed to guide staff in monitoring requirements and monitoring records show all requirements are monitored.

psychosocial needs, and shall address wairuatanga.		restraint monitoring chart.	wairuatanga.	90 days
Criterion 6.3.1 Service providers shall conduct comprehensive reviews at least six-monthly of all restraint practices used by the service, including: (a) That a human rights-based approach underpins the review process; (b) The extent of restraint, the types of restraint being used, and any trends; (c) Mitigating and managing the risk to people and health care and support workers; (d) Progress towards eliminating restraint and development of alternatives to using restraint; (e) Adverse outcomes; (f) Compliance with policies and procedures, and whether changes are required; (g) Whether the approved restraint is necessary; safe; of an appropriate duration; and in accordance with the person’s and health care and support workers’ feedback and current evidenced-based best practice; (h) If the person’s care or support plans identified alternative techniques to	PA Moderate	The policy requires a six-monthly quality review of restraint.	Six-monthly reviews of all restraint practice were not completed as per the policy.	Ensure there is six-monthly quality review of all restraint practice. 60 days

restraint; (i) The person and whānau, perspectives are documented as part of the comprehensive review; (j) Consideration of the role of whānau at the onset and evaluation of restraint; (k) Data collection and analysis (including identifying changes to care or support plans and documenting and analysing learnings from each event); (l) Service provider initiatives and approaches support a restraint-free environment; (m) The outcome of the review is reported to the governance body.				

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.