Kaylex Care (Waipukurau) Limited - Mt Herbert House and Forget-Me-Not-Village

Introduction

This report records the results of a Surveillance Audit of a provider of aged residential care services against the Ngā paerewa Health and disability services standard (NZS8134:2021).

The audit has been conducted by The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to Manatū Hauora (the Ministry of Health).

The abbreviations used in this report are the same as those specified in section 0.4 of the Ngā paerewa Health and disability services standard (NZS8134:2021).

You can view a full copy of the standard on the Manatū Hauora website by clicking here.

The specifics of this audit included:

Legal entity:	Kaylex Care (Waipukurau) Limited
Premises audited:	Mt Herbert House and Forget-Me-Not-Village
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 4 February 2026 End date: 4 February 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

Mt Herbert House and Forget-Me-Not Village is certified to provide rest home, hospital and secure dementia care for up to 62 residents. Mt Herbert House provides rest home and hospital levels of care, and Forget-Me-Not Village provides secure dementia care services. The facility is owned by Kaylex Care (Waipukurau) Limited and is managed by an experienced facility manager.

This surveillance audit process included review of policies and procedures, review of residents' and staff files, observations, and interviews with residents, whānau, a director of the service, the manager, staff, and a general practitioner.

The corrective actions that have been addressed and closed from the two previous (certification and partial provisional) audits relevant to Mt Herbert House include general practitioner and medication review, review of restraint policy, documentation on the restraint register, and restraint consent.

Corrective actions that are closed relating to the Forget-Me-Not Village include recruitment and orientation of staff, a verified food control plan, verification of the call bell system, issuing of a certificate of public use (a building warrant of fitness is in place), and a fire evacuation trial.

Corrective actions not fully addressed from these audits related to communication, the quality system (including completion of neurological observations), registered nurse coverage of the facility, and the restraint process.

As a result of this audit, improvements are required to complaints management, legislative/regulatory reporting, aspects of care planning, and staff orientation and performance review.

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.

Mt Herbert House and Forget-Me-Not Village had Māori and Pacific health policies in place. The policies define the service's commitment to equity for Māori and Pacific peoples and outline appropriate models of care reflecting cultural considerations. Staff were observed to engage with residents in a culturally safe way during the audit.

Residents who identified as Māori were treated equitably and confirmed that their mana motuhake (self-determination) was maintained. Te reo Māori and tikanga Māori were incorporated in daily practices. Pacific peoples were provided with services that recognise their worldviews; residents who identified as a member of a Pacific community confirmed that services delivered were culturally safe. Mt Herbert House and Forget-Me-Not Village responded to tāngata whaikaha (people with disabilities) needs, enabling their participation in te ao Māori.

Residents and their whānau were informed of their rights according to the Code of Health and Disability Services Consumers' Rights (the Code). Residents were safe from abuse and were receiving services in a manner that respected their dignity, privacy, and independence. The service provided services and support to people in a way that was inclusive and respected their identity, choices, and experiences.

Policies and procedures relative to the complaints management processes were in place.

Hunga mahi me te hanganga | Workforce and structure

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

The governing body assumed accountability for delivering a high-quality service. This included ensuring the reduction of barriers to improve outcomes for Māori, Pacific people and tāngata whaikaha.

Planning ensured the purpose, values, direction, scope and goals for the organisation were defined. Most performance indicators were being reviewed at planned intervals.

The clinical governance structure in place was appropriate to the needs of the service.

There was a quality and risk management system in place that was focused on improving service delivery and care. The system required the collection and analysis of quality improvement data to identify trends, leading to improvements.

Staff had the skills, attitudes, qualifications and experience to meet the cultural and clinical needs of residents. Professional qualifications were validated prior to employment.

Staff interviewed reported that they felt well supported by the organisation.

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.

Upon admission to Mt Herbert House or Forget-Me-Not Village, a person-centred and whānau-centred approach was implemented. Appropriate information was provided to prospective residents and their whānau.

Forget-Me-Not Village provided a service that evidenced collaboration with residents and their whānau to assess, plan, and evaluate care. Individualised care plans were developed based on thorough assessments and were updated to address any emerging issues. Documentation reviewed confirmed that care consistently met the needs of residents and their whānau, with regular and timely evaluations. Care plans in Mt Herbert House included evidence of timely assessment and evaluation.

Medications in both areas were managed and administered safely by qualified staff.

The food service in both areas fulfilled residents' nutritional requirements, accommodating specific cultural needs, and adhered to safe food management practices.

Residents were transitioned or transferred to other health services, as necessary.

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.		Subsections applicable to this service are fully attained.

The facility, plant and equipment met the needs of residents in both the main facility and the adjacent secure dementia care village, and these were culturally inclusive. A current building warrant of fitness and planned maintenance programme ensured safety. The call bell system in both Mt Herbert House and the Forget-Me-Not Village had been fully implemented and tested. Residents and their whānau reported timely response to call bells. Electrical and biomedical equipment and hot water testing had been completed as required for both areas.

A Fire and Emergency New Zealand (FENZ)–approved evacuation plan was sighted and trial evacuation procedures embedded for both areas of the service.

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

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

The governing body, the facility manager, and the infection control nurse at Mt Herbert and Forget-Me-Not Village ensured the safety of residents and staff through a planned infection prevention and antimicrobial stewardship programme that was appropriate

to the size and complexity of the service. It was adequately resourced. The experienced and trained infection control nurse led the programme and was engaged in procurement processes.

Aged care-specific infection surveillance was undertaken, with follow-up action taken as required. Surveillance of infections was undertaken, and results were monitored and shared with the organisation's management and staff. Action plans were implemented as and when required.

Here taratahi | Restraint and seclusion

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

The service aims for a restraint-free environment, and this is supported by the service's policies and procedures. There were two residents using three restraints at the time of audit in the main facility; restraint is not in use in the Forget-Me-Not Village. A suitably qualified restraint coordinator, who is a registered nurse, manages the process.

The education programme includes training in the least restrictive practices, de-escalation techniques, and alternative interventions to restraint. Staff interviewed demonstrated a sound knowledge of the restraint process.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Subsection	0	14	0	2	6	0	0
Criteria	0	47	0	4	7	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	Mt Herbert House (Mt Herbert) and Forget-Me-Not Village (the secure dementia care village) had policies, procedures, and processes to embed and enact Te Tiriti o Waitangi in all aspects of its work. Partnerships had been established with two local maraes, and a kaitakawaenga (Māori cultural adviser) from the local Health New Zealand – Te Whatu Ora Māori Support Unit to support service integration, planning, equity approaches and support (including rongoā support) for Māori. The service also engages with Terrace School (a local bilingual school) for the benefit of the school and the Māori residents in the service. A Māori health plan has been developed with input from cultural advisors and is used for residents who identify as Māori. There were Māori residents present in the facility during the audit, and one of the residents acts as a kaumātua for the service. Māori residents and their whānau participated in providing input into their care planning, activities, and dietary needs. Care plans included the physical, spiritual, whānau, and psychological health of the residents. Māori residents and their whānau interviewed reported that they were comfortable at the facility and expressed feelings and experiences that were consistent with cultural safety, confirming that mana motuhake (self-determination) was being respected.

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	The service provider had a health plan in place that described how the service responded to the cultural needs of residents who identified with a Pacific community. The document noted the worldviews of Pacific peoples, the need to embrace cultural and spiritual beliefs, outlined an appropriate model of care specific to residents from Pacific nations, and was focused on achieving equity. A partnership with a Pacific spiritual organisation enabled support for Pacific residents and ongoing planning and evaluation of services and outcomes. There were residents who identified with a Pacific community in the facility on the day of audit; they and their whānau interviewed reported that they were comfortable at the facility and expressed feelings and experiences that were consistent with cultural safety.
Subsection 1.3: My rights during service delivery The People: My rights have meaningful effect through the actions and behaviours of others. Te Tiriti:Service providers recognise Māori mana motuhake (self-determination). As service providers: We provide services and support to people in a way that upholds their rights and complies with legal requirements.	FA	Staff members at Mt Herbert and the secure dementia care village demonstrated a clear understanding of the Code of Health and Disability Services Consumers' Rights (the Code) and were observed providing support to residents in alignment with individual preferences. Residents and their whānau reported being informed about the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service), and indicated they were offered opportunities to discuss and clarify their rights. The Code was on display and brochures were available in the entry foyer. Staff training on the Code had been provided within the past year.
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	Employment practices at Mt Herbert and the secure dementia care village included reference checking and police vetting. Policies and procedures outlined safeguards in place to protect people from discrimination, coercion, harassment, physical, sexual, or other exploitation, abuse, or neglect. Workers followed a code of conduct. Staff understood the service's policy on abuse and neglect, including what to do should there be any signs of such practice. Residents reported that their property and finances were respected. Professional boundaries were

		maintained. Eight residents and seven whānau members interviewed expressed overall satisfaction with the services provided at Mt Herbert and the secure dementia care village. Mention was made by whānau, however, that there was minimal feedback received by them about medical updates, following general practitioner (GP) visits (refer criterion 1.6.3).
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.	PA Moderate	Interviews with residents and whānau verified that residents felt listened to and information was provided in an easy-to-understand format. Interviews with whānau (seven), however, identified that changes to residents' health status was often not communicated to them (refer criterion 1.6.3). A review of incident forms did not evidence that whānau had been contacted following the resident experiencing an incident, and there was no evidence documented in the progress notes that whānau had been informed. Observations identified that staff were not wearing name badges; because of this, residents, whānau and visitors were unable to identify the name of the staff member they were talking to. This finding, previously identified during an earlier (certification) audit, had not been addressed and remains open.
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	FA	Residents at Mt Herbert and the secure dementia care village and/or their whānau/legal representatives were provided with the information necessary to make informed decisions. They felt empowered to actively participate in decision-making. The nursing and care staff interviewed understood the principles and practice of informed consent. Advance care planning, establishing, and documenting of enduring power of attorney (EPOA) requirements, and processes for residents unable to consent were documented, as relevant, in the resident's record. Review of resident files in the secure dementia care village evidenced activated EPOAs, as well as specialist authorisations indicating that residents required care within a secure environment.

make informed decisions in accordance with their rights and their ability to exercise independence, choice, and control.		
Subsection 1.8: I have the right to complain The people: I feel it is easy to make a complaint. When I complain I am taken seriously and receive a timely response. Te Tiriti: Māori and whānau are at the centre of the health and disability system, as active partners in improving the system and their care and support. As service providers: We have a fair, transparent, and equitable system in place to easily receive and resolve or escalate complaints in a manner that leads to quality improvement.	PA Low	A system was in place to receive and resolve complaints; however, the process for managing complaints was haphazard and did not meet the timeframes required to enable the process to be compliant with the Code (refer criterion 1.8.3). Residents and their whānau were being provided with information regarding the complaints process and advocacy services on entry; complaints information was available in te reo Māori. Information regarding the complaints process was displayed in the facility, along with advocacy information. Residents and whānau interviewed understood their right to make a complaint and knew how to do so. There have been 12 complaints received in the last 12 months (two of which were copied to Health New Zealand – Te Whatu Ora (Te Whatu Ora) and had been closed by them). Documentation sighted in respect of the complaints showed that while they had been responded to, this has not occurred within appropriate timeframes. Complainants had been informed of findings following investigation (refer criterion 1.8.3). The FM, who manages complaints, was able to describe the processes the service has in place in policy to ensure complaints from Māori would be treated in a culturally appropriate and equitable fashion. This included the use of an interpreter (if required) and engagement with the resident and their whānau in a way culturally appropriate for them (e.g., with the use of hui and iwi-appropriate tikanga). No complaints had been received from Māori in the service. There was one complaint received by the service in 2025 via the Office of the Health and Disability Commissioner (HDC). The complaint, related to resident care, was referred to the HDC from the Office of the Coroner. The service has responded to the HDC within the appropriate timeframes. The complaint remains open at the time of audit. There have been no further complaints received from external sources since the previous (certification and partial provisional) audits.

Subsection 2.1: Governance The people: I trust the people governing the service to have the knowledge, integrity, and ability to empower the communities they serve. Te Tiriti: Honouring Te Tiriti, Māori participate in governance in partnership, experiencing meaningful inclusion on all governance bodies and having substantive input into organisational operational policies. As service providers: Our governance body is accountable for delivering a highquality service that is responsive, inclusive, and sensitive to the cultural diversity of communities we serve.	FA	Kaylex Care (Waipukurau) Limited (Kaylex Care) directors assume accountability for delivering a high-quality service through culturally appropriate policy and procedures. They have sought to develop services which address the needs of the local community, most recently through the refurbishment of cottages on the adjacent site, known as Forget-Me-Not Village, to meet the support needs of people living with dementia. The directors of Kaylex Care and the facility manager (FM) of Mt Herbert and the secure dementia care village honour Te Tiriti o Waitangi, and are focused on improving outcomes for all residents, including those who are Māori, who identify with a Pacific community, or are tāngata whaikaha. Governance and the FM maintain positive relationships with two local marae and a Kaitakawaenga from the local Te Whatu Ora cultural support unit for organisational support at governance level. One of the directors of Kaylex Care has completed education on Te Tiriti o Waitangi, health equity, and cultural safety to support equitable oversight of the delivery of care. The leadership and clinical structure at Mt Herbert and the secure dementia care village were appropriate to the size and complexity of the service; an experienced and suitably qualified person (the FM) manages the service. While the FM, who is a registered nurse (RN), confirmed knowledge of the sector, including regulatory and reporting requirements, not all the required reporting had been completed (refer criterion 2.2.6). The purpose, values, direction, scope and goals were defined, and monitoring and reviewing of performance occurred through regular reporting to governance at planned intervals. A focus on identifying barriers to access, improving outcomes, and achieving equity for Māori, Pacific peoples, and tāngata whaikaha was evident in plans and monitoring documentation reviewed. Ethnicity data is being collected to support equity. Equity is also supported through choice and control over supports and the removal of barriers that prevent access to information (e.g., information in other languages for the Code, complaints, infection prevention and control, and bilingual signage). The director interviewed reported that they felt well informed on progress and risks. This was confirmed in a sample of reports to the board of directors. Mt Herbert and the secure dementia care village promoted appropriate models of care specific to residents' cultural needs, including for Māori

		and Pacific peoples. There was a Māori health plan in place that guided care for Māori, and a plan to guide care for Pacific people; both of these have had appropriate cultural input. There was no evidence of infrastructural, financial, physical, or other barriers to equitable service delivery. This was supported by interviews with residents and their whānau, managers, and with staff. The service holds contracts with Te Whatu Ora for aged, related rest home and hospital care services, secure dementia care, long-term support – chronic health conditions (LTS-CHC), and short-term care (respite). The service also holds a contract with the Accident Compensation Corporation (ACC) to provide support services. On the day of audit, 40 residents were receiving services: 13 were receiving rest home services (including one on an ACC contract), 24 hospital-level services (including four on LTS-CHC contracts and two on an ACC contract), and three residents receiving care in the secure dementia care village. No residents were receiving care under the respite contract.
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	Policies and procedures reviewed covered all necessary aspects of the service and of contractual requirements and were current. Policies and procedures are outsourced to an external provider; these are used as templates for the facility and edited to reflect the services being provided at Mt Herbert and the secure dementia care village. Policies and procedures related to the care of Māori and Pacific peoples have had input from Māori and Pacific people. Critical analysis of practices and systems, using ethnicity data, identified inequities, and the service worked to address these. Delivering high-quality care to Māori residents is supported through relevant training, tikanga policies, and access to cultural support roles internally and externally. Governance and the FM were committed to quality and risk via policy and processes, and through feedback mechanisms. Most internal quality data information was aggregated, analysed and reviewed; this related to adverse events (refer also criteria 1.6.3 and 2.2.3), infections, and antimicrobial use, with corrective actions completed where deficits are identified. A sample of facility reports and graphs showed adequate information on adverse events, complaints, infections, antimicrobial use, and restraint use had been reported to monitor performance. Staff

		documented adverse and near-miss events in line with the National Adverse Events Reporting Policy but did not appropriately manage communication with residents and their whānau, or with staff (refer criteria 1.6.3 and 2.2.3). Incidents and accidents were investigated and action plans developed. The exception to this was the completion of neurological observations following unwitnessed falls. This was a finding at the previous (certification) audit, and this has not yet been addressed (refer criterion 2.2.3). At the previous (certification) audit, it was also noted that internal auditing, and restraint monitoring had not been completed; this has also not yet been addressed (refer criteria 2.2.3 and 6.2.2). All residents and their whānau have input into quality review of the service through care planning and satisfaction surveys and meetings. Care staff were being supported to complete New Zealand Qualifications Authority (NZQA) health and wellbeing courses, including the specific requirement related to secure dementia care in the village. The FM understood essential notification reporting requirements; however, these had not always been complied with (refer criterion 2.2.6). There have been six Section 31 notifications made to HealthCERT (Manatū Hauora) since the last audit, in relation to a clinical manager (CM) change (one), a resident incident (also referred to the coroner, and subsequently the HDC), and three for RN shortage (between 12 January 2026 and 2 February 2026 – nine shifts). One notification was made on the day of audit for a pressure injury (refer criterion 3.2.3). The service was aware of reporting requirements to the Health Quality & Safety Commission – Te Tāhū Hauora (Te Tāhū Hauora) for all Severity Assessment Code (SAC) reporting at SAC1 and SAC2, as well as pressure injury at stage 3 and above. The FM was having difficulty registering to access the portal to make the notifications, therefore no notification had been made to Te Tāhū Hauora for the stage three pressure injury, or of the resident incident that had been referred to the coroner (refer criterion 2.2.6).
Subsection 2.3: Service management	PA	There is a documented process for determining staffing levels and skill mix to provide culturally and clinically safe care, 24 hours a day, seven

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.	Moderate	days a week (24/7) across Mt Herbert House and the secure dementia care village using a multidisciplinary team (MDT) approach. Staff were able to describe care goals for residents. There was a first aid certified staff member on shift on all of the rosters sighted. The facility had adjusted staffing levels to meet the changing needs of residents. There has been an intermittent shortage of RN cover in the facility since the previous (certification) audit. The service has been unable to fully staff the facility with RNs 24/7 as required by its contract with Te Whatu Ora (refer criterion 2.3.1); shortages are primarily due to RN staff leave and the service is continuing work to recruit enough RNs to cover this. Appropriate Section 31 reporting to HealthCERT had been made. Adjustments to the roster to address this in the short term were discussed with the FM; for instance, by utilising the EN more effectively when the FM or CL (who are both RNs) were on duty. With the exception of a couple of staff members, staff reported that staff numbers (with the exception of RNs) were adequate to allow them to complete the work allocated to them. Review of the rosters for the service supported this. Residents and whānau interviewed supported this, also reporting timely response to call bells. At the previous (partial provisional) audit for the secure dementia care village, there was a finding related to the recruitment of staff for the village; this has been addressed. There were sufficient caregiving staff employed who are appropriately qualified to cover the secure dementia care village as occupancy increases (currently there are three residents in the secure dementia care village); registered nurse cover is provided by the main Mt Herbert facility (refer criterion 2.3.1). The employment process, which included a job description defining the skills, qualifications and attributes for each role, ensured services were delivered to meet the needs of residents. Credentialing of professional health care staff had taken place (RNs, ENs, GP, NP, podiatrist, and pharmacy). Continuing education was planned on an annual basis and included mandatory training requirements. Related competencies had been assessed to support equitable service delivery and the ability to maximise the participation of people using the service and their whānau. High-quality Māori health information was accessible, and this was used to support training and development programmes, and care delivery.

		Records reviewed demonstrated completion of the required training and competency assessments. Staff reported feeling well supported and safe in the workplace. There are policies and procedures in place around wellness, bullying and harassment. Care staff have either completed or commenced a New Zealand Qualifications Authority education programme to meet the requirements of the provider's agreement with Te Whatu Ora. Twenty (20) caregiving staff (from a potential 27) were NZQA–qualified to Level 4, four to Level 3, and three to Level 2. For those staff who primarily worked in the secure dementia care village, two staff were enrolled in the NZQA dementia Limited Credit Programme (LCP), and the rest were either Level 4 or had completed the LCP programme.
Subsection 2.4: Health care and support workers The people: People providing my support have knowledge, skills, values, and attitudes that align with my needs. A diverse mix of people in adequate numbers meet my needs. Te Tiriti: Service providers actively recruit and retain a Māori health workforce and invest in building and maintaining their capacity and capability to deliver health care that meets the needs of Māori. As service providers: We have sufficient health care and support workers who are skilled and qualified to provide clinically and culturally safe, respectful, quality care and services.	PA Low	Established human resources management policies and processes were based on good employment practice and relevant legislation. A sample of seven staff records reviewed confirmed the organisation's policies were being implemented, with the exception of some orientation and performance appraisals (refer criteria 2.4.4 and 2.4.5). Professional qualifications for health care professionals had been validated during recruitment and then checked and documented annually. Police vetting, reference checking, and visa authentication was in place. Job descriptions were documented for each role across the organisation. The job descriptions described the skills and knowledge required of each position, and identified the outcomes, accountability, responsibilities, authority, and functions to be achieved. Staff interviewed reported that the induction and orientation programme had taken place and that it prepared them well for their role; however, orientation for staff was not sighted in all the staff files reviewed (refer criterion 2.4.4). Orientation for the staff employed for the new secure dementia care village was a finding in the previous (partial provisional) audit and this had been addressed; all staff working in that area had been orientated to that service. Staff interviewed also described the performance review process as

		useful for them, allowing them to set their own career and education goals; however, performance appraisal had not occurred within the past year in four of the seven staff files reviewed (refer criterion 2.4.5).
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	A multidisciplinary team at Mt Herbert and the secure dementia care village collaborated with residents to support resident wellbeing. A review was conducted of seven resident files, including three hospital-level care files (two being of residents receiving care under a long-term chronic health contract), three rest home-level care files (including care being provided under an ACC contract), and one file pertaining to a resident receiving care in the secure dementia care village. The records encompassed cases involving residents with pressure injuries or at risk of developing them, those exhibiting challenging behaviours, those who identified as Māori, as well as residents with multiple co-morbidities. A review of the files confirmed that an RN developed a care plan after comprehensive assessment, considering the individual's experience, cultural needs, values, beliefs, and service integration as needed. Assessments were based on a range of clinical assessments and included the resident and whānau input (as applicable). Timeframes for the initial assessment, GP input, initial care plan, long-term care plan, short-term care plans, and review/evaluation timeframes met contractual requirements. This was verified by reviewing documentation, sampling residents' records, interviews, and from observation. The management of specific medical conditions for residents within the service was not well documented in the care plan. Despite the documentation not being in place, observations verified residents were receiving the care they required. Where progress differed from expectations, or changes had occurred, adjustments to the care plan had not been documented or implemented, and there had been no collaboration with the resident and/or whānau (see criteria 1.6.3, and 3.2.3). Interviews with six whānau of other residents, excluding the concerns related to not being kept updated (refer criterion 1.6.3), expressed satisfaction with the care provided at Mt Herbert and the secure dementia care village. The residents and their whānau were actively involved in

		planning the residents' care. Whānau of residents who identified as Māori were complimentary of the cultural support provided, and the responsiveness of staff to residents' needs. Interviews with the staff identified that they were familiar with all aspects of the care residents required, including the cultural aspects of the Māori residents. An interview with the GP expressed satisfaction with the care provided by Mt Herbert House and the secure dementia care village. A corrective action identified at previous (certification and partial provisional) audits related to the non-completion of medical, pharmaceutical and interRAI assessments had been addressed. The service has a GP visiting regularly and interRAI, medical and pharmaceutical assessments were all up to date.
Subsection 3.4: My medication The people: I receive my medication and blood products in a safe and timely manner. Te Tiriti: Service providers shall support and advocate for Māori to access appropriate medication and blood products. As service providers: We ensure people receive their medication and blood products in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	The medication management policy was current and in line with the Medicines Care Guide for Residential Aged Care. A safe system for medicine management using an electronic system was sighted on the day of the audit. All staff who administer medicines had been assessed as competent to perform the function they managed. There was a process in place to identify, record, and document residents' medication sensitivities, allergies, and the action required for adverse events. Medications were supplied to the facility from a contracted pharmacy. Medication reconciliation occurred. All medications sighted were within current use-by dates. Medicines were stored safely, including controlled drugs. The required stock checks were completed. The medicines stored were within the recommended temperature range. There were no vaccines stored on site. Prescribing practices met requirements. The required three-monthly GP review was recorded on the medicine chart. Standing orders were not used at Mt Herbert House or the secure dementia care village. Self-administration of medication was facilitated and managed safely. Residents, including Māori residents and their whānau, were 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 needs are met to promote and maintain their health and wellbeing.	FA	The food service provided at Mt Herbert and the secure dementia care village was in line with recognised nutritional guidelines for older people. The menu was reviewed by a qualified dietitian in December 2025. Recommendations made at that time had been implemented. A previous (partial provisional) audit identified a requirement in the secure dementia care village for the food verification body to approve the most suitable food safety plan for the service; this has been addressed. The service operated with an approved food safety plan and registration. A verification audit of the food control plan was undertaken on 4 December 2025. Ten areas requiring corrective action were identified; these had been addressed and signed off. The plan was verified for 18 months. The plan is due for re-audit in June 2027. Each resident had a nutritional assessment on admission to the facility. Their personal food preferences, any special diets, cultural preferences, and modified texture requirements were accommodated in the daily meal plan. All residents had opportunities to request meals of their choice, and the kitchen would address this. Interviews, observations, and documentation verified residents were satisfied with the meals provided. Evidence of residents' satisfaction with meals was verified by resident and whānau interviews. Food and fluids were available in the secure dementia care village, at any time of the day or night.
Subsection 3.6: Transition, transfer, and discharge The people: I work together with my service provider so they know what matters to me, and we can decide what best supports my wellbeing when I leave the service. Te Tiriti: Service providers advocate for Māori to ensure they and whānau receive the necessary support during their transition, 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	FA	Transfer or discharge from the service was planned and managed safely to cover each resident's current needs and mitigate risk. The plan was developed with coordination between services and in collaboration with the resident and whānau.

support.		
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.	FA	Appropriate systems were in place to ensure the physical environment and facilities (internal and external) for the care home and the secure dementia care village were fit for their purpose, well maintained, and that they met legislative requirements. There were areas external to the care home, and within the secure dementia care village, for leisure activities with appropriate seating and shade. The main Mt Herbert House and the secure dementia care village were culturally inclusive, including signage and artwork suited to the needs of the resident groups. Both environments were comfortable and accessible, promoting independence and safe mobility, and minimising risk of harm. Personalised equipment was available for residents with disabilities to meet their needs, and residents were observed to be safely using these. Spaces included smaller private spaces for residents and their whānau. Lounge and dining facilities met the needs of residents, and these are also used for activities. Wi-Fi was available for residents and whānau to use, and access to equipment needed by tāngata whaikaha enabled. There was a building warrant of fitness in place that covers both service areas, expiring on 1 April 2026. Previous conditions from the Certificate of Public Use for the secure dementia care village in relation to an operable fire and sprinkler system and emergency lighting had been addressed. A planned maintenance schedule included electrical testing and tagging, resident equipment checks, and calibrations of clinical equipment. Monthly hot water tests were completed for resident areas; these were sighted and were all within normal limits.
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	FA	The fire evacuation plan for both Mt Herbert House and the secure dementia care village was approved by Fire and Emergency New Zealand (FENZ) on 22 September 2025. The requirements of the fire and emergency scheme are reflected in the fire and emergency management plan. Staff had been trained in fire and emergency management and knew what to do in an emergency. Fire evacuation drills are required six-monthly; the most recent fire evacuation drill was on 29 October 2025; the

event.		evacuation drill took into account the secure dementia care village and addressed a finding from the previous (partial provisional) audit. The call bell system for the service covers the main care facility and has been extended to cover the secure dementia care village; the functionality of the system in the secure dementia care village had been tested and this was performing well, addressing a finding from the previous (partial provisional) audit. Residents and whānau across both spaces reported that staff respond promptly to call bells. The call bell system in the secure dementia care village relies on motion sensors on closed-circuit television (CCTV) cameras to alert staff if residents leave their room (into communal areas) when staff are not present; the call goes to pagers carried by the care companions.
Subsection 5.2: The infection prevention programme and implementation The people: I trust my provider is committed to implementing policies, systems, and processes to manage my risk of infection. Te Tiriti: The infection prevention programme is culturally safe. Communication about the programme is easy to access and navigate and messages are clear and relevant. As service providers: We develop and implement an infection prevention programme that is appropriate to the needs, size, and scope of our services.	FA	The infection prevention (IP) and antimicrobial stewardship (AMS) programmes were appropriate to the size and complexity of the service, had been approved by the governing body, linked to the quality improvement system, and had been reviewed and reported on yearly. Expertise and advice were being sought following a defined process. A documented pathway supported risk-based reporting of progress, issues, and significant events to the governing body. Staff were familiar with policies through education during orientation (refer criterion 2.4.4), and ongoing education, and were observed following these correctly. Residents and their whānau were educated about IP in a manner that met their needs.
Subsection 5.4: Surveillance of health care-associated infection (HAI) The people: My health and progress are monitored as part of the surveillance programme. Te Tiriti: Surveillance is culturally safe and monitored by ethnicity. As service providers: We carry out surveillance of HAIs and multi-drug-resistant organisms in accordance with national and regional surveillance programmes, agreed objectives,	FA	Mt Herbert and the secure dementia care village undertook surveillance of infections appropriate to that recommended for long-term care facilities and this was in line with priorities defined in the infection control programme. The service used standardised surveillance definitions to identify and classify infection events that relate to the type of infection under surveillance. Monthly surveillance data including ethnicity was collated and analysed to identify any trends, possible causative factors, and required actions. Results of the surveillance programme were reported to the governing

priorities, and methods specified in the infection prevention programme, and with an equity focus.		body and shared with staff.
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	A restraint-free environment is the aim of the service; this is documented in the facility's policy and included consideration of residents housed in the secure dementia care village (restraint is not used in the village). This addresses a finding from the previous (partial provisional) audit related to consideration of the secure dementia care environment. A director of the service interviewed demonstrated their commitment to safe restraint elimination and the facility is working with residents and their whānau to achieve this where this is possible. At the time of audit, two residents were using three restraints in the main care facility (one was using bedrails and the other bedrails and a chest harness). This is a reduction from four residents using six restraints at the previous (certification) audit. There were strategies in place in the service to eliminate restraint, including an investment in equipment to support the removal of restraint (e.g., through the use of 'intentional rounding' (scheduled resident checks), high/low beds, and sensor equipment). Documentation confirmed that aggregated information on restraint use was discussed at facility level and was part of the facility's clinical reporting to the directors of the service. The restraint coordinator (RC) was a defined role undertaken by a RN who provides support and oversight of restraint use. There was a job description in place that outlined the role, and the RC has had specific education around restraint and its use. The RC, in consultation with the GP and the multidisciplinary team, was responsible for the approval of the use of restraint; there were clear lines of accountability. For any decision to use or not use restraint, there is a process to involve the resident, their EPOA and/or whānau as part of the decision-making and consent process. Staff had been trained in the management of behaviours that challenge, least restrictive practice, safe restraint practice, alternative cultural-specific interventions, de-escalation techniques, and restraint monitoring as part of orientation (refer also criterion 2.4.4), and through the education

		programme.
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	When restraint was used, this was as a last resort when all alternatives had been explored. Observation during the audit showed that three restraints were in use for two residents. Restraint records showed that consent had been obtained for the use of all three restraints currently in use, addressing a finding from the previous certification audit. Cultural considerations had been included in the assessments. On the consent and assessment forms, there was evidence of whānau involvement in the processes. The resident's GP was also involved in the restraint process. Access to advocacy is facilitated, as necessary. Monitoring of restraint was overseen by the RC, and this takes into consideration the person's physical, psychological and psychosocial needs and addresses wairuatanga. Whilst some monitoring had taken place, monitoring was not being completed to the requirements assessed for the residents for the restraints in use. This was a finding from the previous (certification) audit, and this had not been fully addressed (refer criterion 6.2.2). The RC continues to maintain a restraint register; the criteria on the restraint register contained enough information to provide a record of restraint use for the three restraints in use; this addresses a finding from the previous (certification) audit. Restraint was considered during the individualised care planning process; this also addresses a finding from the previous (certification) audit. Restraint was only being considered when all other interventions had failed. Any changes to policies, guidelines, education and processes are implemented if indicated. Evaluation of restraint was also a finding from the previous (certification) audit, and this had not been addressed. Evaluation of all three restraints in use was due in December 2025, but these had not been completed (refer criterion 6.2.7). No emergency restraint has been used by the service, but the protocols for this have been described in policy and can only be used in extreme circumstances (in the event of a potential serious injury to the resident or another person). Emergency restraint would be reported as a significant

		event and debrief would be available following the event.
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	Policies and procedures were sourced from an external source and updated by them if change was indicated. Minutes from meetings within the service did not evidence discussion of restraint use. Registered nurses (RNs) in the service meet three-monthly, but minutes indicated this was a general 'catch-up' meeting. There was no indication in the minutes that restraint use had been discussed in any depth and no evidence that the service undertakes a six-monthly review of all restraint use that includes all the requirements of the Standard (refer criterion 6.2.3). This was identified as a corrective action at the previous (certification) audit, and this has not been addressed. The use of restraint has decreased from six to three since the last (certification) audit; acuity of residents using the restraints supports their use.

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 1.6.3 My service provider shall practise open communication with me.	PA Moderate	Interviews with residents identified that they felt listened to. Interviews with the whānau of residents who reside in Mt Herbert identified they were not informed when the resident had been seen by the GP or informed of any update or any changes made related to the care of their family member. Residents and whānau of residents residing in the secure dementia care village felt that they were kept well informed. Incident forms reviewed did not evidence whānau had been contacted following an incident. Progress notes did not include documentation that whānau had been contacted when changes	Mt Herbert staff do not always keep whānau informed of medical updates, incidents or accidents, or changes in the residents’ condition. Residents, visitors and whānau are unaware of the names of staff members.	Provide evidence that Mt Herbert keeps whānau informed of changes in residents’ condition, medical updates, and accidents and incidents. Ensure staff wear name badges to enable residents, whānau and visitors to identify who they are talking to. 30 days

		occurred (refer also criterion 2.2.5). Staff were not wearing name badges.		
Criterion 1.8.3 My complaint shall be addressed and resolved in accordance with the Code of Health and Disability Services Consumers' Rights.	PA Low	There is a complaints policy in place that met the requirements of the Code. Twelve complaints were received by the service and seven of these were looked at in detail. Complainants of all the seven complaints received by the service had been notified of the outcome of their complaint. However, the service did not follow its policy and procedures in the management of its complaints, only two (of the seven complaints) had been sent an acknowledgement of their complaint within the required five days (the longest was 20 days), and not all of the complainants had acknowledged their satisfaction of the complaint outcome. Added to this, the restraint register was fragmented (there were two processes running simultaneously) and there was no indication in any correspondence of the complainants right to refer their complaint to the HDC if they were not satisfied with the outcome of their complaint.	The service did not comply with Right 10 of the Code, which requires consumers to have their complaints managed fairly, promptly, and in accordance with policy. Complainants had not been made aware in any correspondence of their right to forward their complaint to the HDC if they were not satisfied with the outcome of their complaint. An accurate, integrated restraint register was not in place.	Provide evidence that the service has reviewed and strengthened its complaints management system to ensure full compliance with Right 10 of the Code. Provide evidence that information on the right of the complainant to refer their complaint to the HDC if they were not satisfied with the outcome of their complaint had been provided, and that the restraint register is accurate and integrated. 90 days
Criterion 2.2.3 Service providers shall evaluate	PA Moderate	At the previous (certification) audit it was identified that the internal	The internal audit schedule has not been adhered to, and not all	Provide evidence that the internal audit schedule is being

progress against quality outcomes.		audit schedule had not been adhered to, and not all internal audits have been fully completed with corrective actions generated and addressed as required through policy. There was also no record of neurological observation having been fully completed following unwitnessed falls. At this audit, it was identified that these issues had not yet been addressed. Not all audits had been completed to the schedule throughout 2025/2026, and neurological observations and whānau communication (refer also criterion 1.6.3) had not occurred in the records of three unwitnessed falls examined in detail (from 11 unwitnessed falls over a period of one month). The internal auditing system in use required 80 internal audits in 2025 (some monthly, some bi-monthly, and some once or twice a year); of these, nine had been addressed relating to maintenance (one), wheelchair maintenance (two), complaints (one – refer also to criterion 1.8.3), medication management (two), clinical records (two), and privacy/Our Rights (one). Of note, not all the audits had been completed, and not all corrective actions (as identified) had been addressed (the oldest was from February 2025). No audits had been	internal audits have been fully completed with corrective actions generated and addressed as required through policy. There was no record of neurological observation having been fully completed following unwitnessed falls or of communication to whānau regarding the fall.	adhered to, with findings and corrective actions documented and addressed. Provide evidence that unwitnessed falls are having neurological observations fully completed and that whānau are being communicated with following the fall. 60 days

		completed in 2026. In the records of three residents who had experienced an unwitnessed fall, none had any neurological observations on file, except for an initial set taken immediately following the fall being discovered, and there was no record in any of the resident files reviewed to show that whānau had been informed of the fall.		
Criterion 2.2.6 Service providers shall understand and comply with statutory and regulatory obligations in relation to essential notification reporting.	PA Moderate	The FM was aware of the requirement to report all SAC1 and SAC2 incidents and pressure injuries at stage three and above to Te Tāhū Hauora. The FM is having difficulty accessing the portal to report incidents. Evidence was sighted of two emails sent to Te Tāhū Hauora requesting assistance. A telephone call was also made on the day of audit. Two notifications that should have been made, had not been able to be made. One notification related to a stage three pressure injury that was discovered on the day of audit; the second a resident incident that had been referred to the coroner.	Appropriate and timely notifications of SAC1 and SAC2 incidents and pressure injuries to Te Tāhū Hauora was not occurring due to the inability to access the portal for reporting.	Provide evidence that the FM has access to the reporting portal of Te Tāhū Hauora, and that the required notifications to Te Tāhū Hauora have been made. 90 days
Criterion 2.3.1	PA	The service employs seven RNs, two of whom are the FM and the	Not all shifts at the facility were covered by an RN as required	Provide evidence that sufficient numbers of RNs are employed

Service providers shall ensure there are sufficient health care and support workers on duty at all times to provide culturally and clinically safe services.	Moderate	clinical lead (CL). The service is continuing to have difficulty covering shifts when RNs are on leave and not all shifts had been covered by RNs on the four weeks of roster reviewed in detail during the audit (as required by the service's contract with Te Whatu Ora). On the four weeks of roster reviewed, nine shifts were covered by a medication-competent enrolled nurse (EN) in the absence of an RN on site (there was an RN on call who is within 10 minutes travel to the facility and can attend if this is needed). Three of these were afternoon shifts and six were night shifts. Appropriate Section 31 notifications (covering the nine shifts) had been made to HealthCERT in relation to RN cover, the last being on 2 February 2026. In addition to this, three RNs had been required to double their shift (one doing a morning and afternoon shift, and two doing an afternoon and night shift) on the rosters reviewed. While this meant that there was an RN in the facility, potential tiredness was a risk to clinically safe services.	under the service's contract with Te Whatu Ora. There are insufficient RNs employed to cover RN leave.	to cover the facility 24/7, including when RN staff are on leave. 180 days
Criterion 2.4.4 Health care and support workers	PA Low	Orientation for staff was a requirement of the service's policy. While staff reported that	Not all staff have been fully orientated to their role.	Provide evidence that all staff have been fully orientated to

shall receive an orientation and induction programme that covers the essential components of the service provided.		orientation did take place and that it prepared them for their role, documentation to support this was not sighted in all the staff files reviewed. From the seven records reviewed in detail, four staff had not been fully orientated to their role. One orientation was in progress. These were the EN (no orientation documented), a housekeeper who had been orientated to the kitchen but not their housekeeping role, and the CL who had been orientated to the RN role but not the CL role.		their role. 180 days
Criterion 2.4.5 Health care and support workers shall have the opportunity to discuss and review performance at defined intervals.	PA Low	Annual performance appraisal was a requirement of the service's policy. While staff reported that performance appraisals was completed with them, documentation to support this was not sighted in all of the staff files reviewed. From the seven records reviewed in detail, four did not have a completed performance appraisal in place for either 2025 or 2026.	Not all staff have had a performance appraisal completed annually.	Provide evidence that performance appraisals are being completed annually for all staff. 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;	PA Moderate	An RN developed a care plan for each resident in a timely manner; however, a review of seven care plans evidenced that four of the seven files did not include documentation that addressed all	Four of seven care plans reviewed did not describe fully all the care the residents required to meet their needs.	Provide evidence that care plans describe fully all the care the residents require to meet their needs.

(b) A suitably qualified, skilled, and experienced health care or support worker undertakes the development of the care or support plan; (c) Comprehensive assessment includes consideration of people's lived experience; (d) Cultural needs, values, and beliefs are considered; (e) Cultural assessments are completed by culturally competent workers and are 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.		the care these residents required. A GP's request for a resident to wear compression stockings daily was not documented in the resident's care plan. A resident who had developed a pressure injury had a pressure injury risk identifying that the sacrum was at risk, with strategies to minimise the risk in place. However, the risk to other areas was not identified and subsequently a pressure injury had developed. The resident was high risk of this occurring. A resident assessed as 'prone to choking' had no plan documented to minimise the risk. A resident with a previous condition that had gone into remission had no documentation that identified its potential for recurrence. A resident who had a recent unwitnessed fall had no neurological observations completed (refer criterion 2.3.2). A skin assessment in the care plan had no documentation verifying a pressure injury or a potential risk for developing one. Documentation evidenced a 'likely pressure injury' had occurred and a photograph two weeks later evidenced a stage three injury, and a wound care plan. A Section 31 notification of the injury was submitted to Manatū Hauora on the day of audit (refer also criterion 2.2.6). A recent swab identified a wound infection		90 days

		requiring infection prevention and control practices to be implemented. While these were occurring, there was no documentation in the care plan regarding the plan of care in place to manage the risk of infection to others. Evidence was heard of the process being handed over to staff verbally. The resident was an insulin-dependent diabetic and there was no plan of care to manage this.		
Criterion 6.2.2 The frequency and extent of monitoring of people during restraint shall be determined by a registered health professional and implemented according to this determination.	PA Low	The monitoring for restraint use is set out in policy, with a requirement that monitoring is to be no less than two-hourly. The policy requires that a RN assess the appropriate monitoring for each restraint, dependent on risk to the resident. This function is carried out by the RC, who is a RN, and who has the knowledge and experience to undertake the assessments. The monitoring frequency for the three restraints in use was set at two-hourly. Records reviewed showed that, while some monitoring had taken place, the monitoring had not been consistent and did not meet the assessed requirements.	The frequency and extent of monitoring of residents using restraint had been determined by the RC but the monitoring regime had not consistently been adhered to.	Ensure the frequency and extent of monitoring of residents using restraint is documented and that monitoring is consistently implemented when residents are using a restraint. 180 days
Criterion 6.2.7	PA	All of the restraints in use required	Evaluation of the use of restraint	Provide evidence that

Each episode of restraint shall be evaluated, and service providers shall consider: (a) Time intervals between the debrief process and evaluation processes shall be determined by the nature and risk of the restraint being used; (b) The type of restraint used; (c) Whether the person's care or support plan, and advance directives or preferences, where in place, were followed; (d) The impact the restraint had on the person. This shall inform changes to the person's care or support plan, resulting from the person-centred and whānaucentred approach/reflections debrief; (e) The impact the restraint had on others (for example, health care and support workers, whānau, and other people); (f) The duration of the restraint episode and whether this was the least amount of time required; (g) Evidence that other de-escalation options were explored; (h) Whether appropriate advocacy or support was provided or facilitated; (i) Whether the observations and monitoring were adequate and maintained the safety of the person; (j) Future options to avoid the use of restraint; (k) Suggested changes or	Moderate	three-monthly evaluation and all were due for evaluation in December 2025, but this had not taken place. None of the restraints in use had been evaluated since October 2025.	had not been undertaken three-monthly as required.	evaluation of restraint use is being completed at three-monthly intervals. 90 days

additions to de-escalation education for health care and support workers; (l) The outcomes of the person-centred debrief; (m) Review or modification required to the person's care or support plan in collaboration with the person and whānau; (n) A review of health care and support workers' requirements (for example, whether there was adequate senior staffing, whether there were patterns in staffing that indicated a specific health care and support workers issue, and whether health care and support workers were culturally competent).				
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	PA Moderate	There has been no six-monthly review of restraint as required by the Standard. While RN meetings have taken place, the minutes from the meetings do not evidence that restraint has been discussed in enough detail to meet the requirements of the Standard.	Six-monthly review of the use of restraint has not taken place.	Provide evidence that six-monthly review of the use of restraint is taking place. 90 days

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 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.