Lady Wigram Limited - Lady Wigram 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 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:	Lady Wigram Limited
Premises audited:	Lady Wigram 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: 3 March 2026 End date: 4 March 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: 133

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Lady Wigram Village is certified to provide hospital (geriatric and medical), rest home, and dementia level care for up to 140 residents. There were 133 residents on the days of the audit.

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

The care facility manager is supported by a clinical manager, clinical coordinators and a team of experienced registered nurses and caregivers. There are quality systems and processes being implemented. Feedback from residents and family/whānau was positive about the care and the services provided. An induction and in-service training programme are in place to provide staff with appropriate knowledge and skills to deliver care.

There were no shortfalls identified at the previous certification audit.

This surveillance audit has identified a shortfall in the implementation of the quality programme.

Ō tātou motika | Our rights

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

There is a Māori health plan in place for the organisation. Te Tiriti o Waitangi is embedded and enacted across policies, procedures, and delivery of care. The service recognises Māori mana motuhake and this is reflected in the Māori health plan and business plan. A Pacific health plan is in place which ensures cultural safety for Pacific peoples, embracing their worldviews, cultural, and spiritual beliefs.

Lady Wigram Village demonstrates their knowledge and understanding of resident's rights and ensures that residents are well informed in respect of these. Residents are kept safe from abuse, and staff are aware of professional boundaries.

There are established systems to facilitate informed consent and to protect resident's property and finances. The complaints process is responsive, fair, and equitable. Complainants are kept informed of outcomes following any investigation.

Hunga mahi me te hanganga | Workforce and structure

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

Lady Wigram Village is family owned. Lady Wigram Village has a business and quality plan in place for 2026 with documented site-specific goals, which are regularly reviewed. Barriers to health equity are identified, addressed, and services delivered that improve outcomes for Māori.

There is a process for following the National Adverse Event Reporting Policy and management comply with statutory and regulatory obligations in relation to essential notification reporting.

There is a staffing and rostering policy. Human resources are managed in accordance with good employment practice. Regular staff education and training is in place to support staff in delivering safe, and quality care.

Ngā huarahi ki te oranga | Pathways to wellbeing

Includes eight subsections that support an outcome where people participate in the development of their pathway to wellbeing, and receive timely assessment, followed by services that are planned, coordinated, and delivered in a manner that is tailored to their needs.		Subsections applicable to this service fully attained.

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

Medication policies reflect legislative requirements and guidelines. All staff responsible for administration of medication complete education and medication competencies. The medication charts reviewed met prescribing requirements and were reviewed at least three-monthly by the general practitioner.

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

All residents' transfers and referrals are coordinated with residents and 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.		Subsections applicable to this service fully attained.

The facility holds a current building warrant of fitness. Electrical equipment has been tested and tagged. All medical equipment has been serviced and calibrated.

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

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

All policies, procedures, the pandemic plan, and the infection control programme have been developed and approved by the governing body. Infection control education is provided to staff at the start of their employment, and as part of the annual education plan.

Surveillance data is undertaken, including the use of standardised surveillance definitions, and ethnicity data. Infection incidents are collected and analysed for trends and the information used to identify opportunities for improvements. There had been two outbreaks since the last audit.

Here taratahi | Restraint and seclusion

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

The governance body demonstrates a commitment to restraint elimination. The facility had no residents using restraints at the time of audit. Eliminating restraint and management of behaviour is included as part of the education and training plan. The service considers least restrictive practices, implementing de-escalation techniques and alternative interventions, and only uses an approved restraint as the last resort

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Subsection	0	17	0	1	0	0	0
Criteria	0	48	0	1	0	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	The Māori health plan acknowledges Te Tiriti o Waitangi as the founding document for New Zealand. Lady Wigram Village is committed to respecting the self-determination, cultural values, and beliefs of Māori residents and family/whānau. At the time of the audit there were residents and staff who identified as Māori. Staff who identified as Māori confirmed in interview that mana motuhake is recognised, and this was also evident in the care plans reviewed.
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 Pacific Health and Wellbeing Plan 2020-2025 is the basis of the Lady Wigram Village Pacific health plan. At the time of the audit there were no residents who identified as Pasifika. Lady Wigram Village has a diverse workforce that includes Pasifika employees. The staff confirmed that cultural safety for Pacific peoples, their worldviews, cultural and spiritual beliefs are embraced.

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 care facility manager and clinical manager discussed how the welcome packs are given in the language most appropriate for the resident, to ensure they are fully informed of their rights. Five residents (four hospital and one rest home) and three family/whānau (two dementia care and one hospital) interviewed stated that all staff respected their rights.
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	Lady Wigram Village policies documents guidelines to prevent any form of institutional racism, discrimination, coercion, harassment, or any other exploitation. There are established policies and protocols to respect resident's property, and an established process to manage and protect resident finances. In the interest of minimising risk of resident abuse, all potential employees are asked to consent to a character check, a police check, and work history reference checks. All staff have received education around and are aware of professional boundaries, as evidenced in orientation documents and ongoing education records. Staff interviewed including six caregivers including a Careerforce assessor, six registered nurses [RNs] (including three clinical coordinators and educator coordinator); and five managers (the general manager, the care facility manager, clinical manager, kitchen manager and property manager), interviewed demonstrated an understanding of professional boundaries.
Subsection 1.7: I am informed and able to make choices The people: I know I will be asked for my views. My choices will be respected when making decisions about my wellbeing. If my choices cannot be upheld, I will be provided with information that supports me to understand why. Te Tiriti: High-quality services are provided that are easy to access and navigate. Providers give clear and relevant	FA	There are policies around informed choice and consent. Eight resident files reviewed included informed consent forms signed by either the resident or the resident power of attorney (EPOA). Staff and management have a good understanding of the organisational process to ensure informed consent for all residents including Māori, who may wish to involve family/whānau for collective decision making. Interviews with family/whānau and residents confirmed their choices

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.		regarding decisions, and their wellbeing is respected. Consent forms were appropriately signed by the activated EPOA or welfare guardian. All documentation regarding EPOA, and activation (where required) is on file including on behalf of residents in the dementia unit.
Subsection 1.8: I have the right to complain The people: I feel it is easy to make a complaint. When I complain I am taken seriously and receive a timely response. Te Tiriti: Māori and whānau are at the centre of the health and disability system, as active partners in improving the system and their care and support. As service providers: We have a fair, transparent, and equitable system in place to easily receive and resolve or escalate complaints in a manner that leads to quality improvement.	FA	The complaints procedure is provided to residents and family/whānau during the resident's entry to the service. A comprehensive information pack includes information on access to advocacy and complaint support systems. The Code is visible, and available in te reo Māori, and English. Discussions with residents and families/whānau confirmed that they were provided with information on the complaints process and remarked that any concerns or issues they had, were addressed promptly. The care facility manager is responsible for the management of complaints and is able to provide Māori residents with support to ensure an equitable complaints process. A complaints register is maintained, which includes all complaints, dates and actions taken. There have been twenty complaints received since the last audit. Documentation reviewed included acknowledgement, follow up and outcome resolution, which demonstrates that complaints are being managed in accordance with guidelines set by the HDC. There was one complaint in 2025 that was still open and pending investigations from another involved agency. The Ministry of Health requested follow up against aspects of a complaint made in 2022 that included (criterion # 2.3.4) in relation to care staff/registered nurse training for recognising acute deterioration, delirium, falls, and fractures. There were no issues identified in this audit in respect of this complaint. Information about the support resources for Māori is available to staff to assist Māori in the complaints process. Interpreters contact details are available. The facility manager acknowledged their understanding that for Māori, there is a preference for face-to-face communication and to include whānau participation.

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	Lady Wigram Village is located in Wigram, Christchurch and is part of a wider retirement village. The service provides care for up to 140 residents at hospital (medical and geriatric), rest home and dementia level care. At the time of the audit there were 133 residents in total. The rest home unit has 40 beds and there were 35 rest home residents, including one on respite care. The hospital unit has 60 dual-purpose beds and there were 59 residents in total: 53 hospital residents (including one resident on respite care and six rest home residents). There are two secure dementia units; the Corsair unit has 20 beds with 19 dementia residents, and the Skyhawk unit has 20 beds with 20 dementia residents. All other residents were on the aged related residential contract (ARRC). There were no shared/double rooms. Lady Wigram Village is a family-owned business. There is a director/owner, and a general manager who oversee the Lady Wigram Village facility. The general manager interviewed confirmed there were no changes made to the governance structure since the last audit. The care facility manager and clinical manager report to the general manager. The director/owner visits the site on a regular basis and meets monthly with the general manager, care facility manager, and clinical manager (executive team) to discuss all matters related to governance. The general manager actively engages with residents and staff, as evidenced through observations and interviews. The executive team ensures compliance with legislative, contractual, and regulatory requirements as evidence through the bimonthly executive meeting and quality meeting minutes. There has been a change in the management team since the last audit. The care facility manager, (a registered nurse) and clinical manager have both been in their roles since early 2025. Both had many years experienced with other aged care organisations in similar roles. They are supported by three clinical coordinators, the property manager, kitchen manager, educator coordinator, and finance manager. Lady Wigram Village current business plan 2025-2027 identifies annual goals and measures. The organisation structure, purpose, vision, values, mission statement, performance and goals are clearly identified, monitored, reviewed, and evaluated at defined intervals. The goals relate

		to business and services; leadership and management; financial leadership and management; risk management and marketing; advertising and promotion; and clinical quality goals related to wound management and pressure injury prevention; decrease of medication errors; and compliance of clinical documentation. The business plan includes service development that support outcomes to achieve equity and addresses barriers for Māori, as documented in the business plan. Clinical governance is overseen by the care facility manager, clinical manager, and three clinical coordinators. There is a monthly quality improvement meeting and bimonthly governance (executive team) meetings. All high-risk areas are discussed alongside corrective measures taken. These measures are then reviewed and adapted until a positive outcome is achieved, or the goal is achieved. The general manager attends both the meetings. The care facility manager and the clinical manager have completed other professional development activities in excess of eight hours annually, related to managing an aged care facility.
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 Low	There is an organisational quality and risk management programme documented. The quality and risk management systems include performance monitoring through internal audits and through the collection of clinical indicator data. There is an annual meeting schedule that includes monthly quality improvement, health and safety, staff, RN/clinical and resident meetings. The meetings provide an avenue for discussions in relation to (but not limited to): infection control; complaints received (if any); staffing; education; quality data; health and safety; hazards; service improvement plans; incidents and accidents; internal audits; and infections. All agenda items, discussion points and actions have been evidenced as being followed up or completed. Meeting minutes evidence staff are informed of the performance of the service; however, infection control surveillance including antimicrobial stewardship discussions are not always documented as occurring. The most recent resident and family/whānau survey was in October 2025 with overall positive results and an overall satisfaction of 89%. Corrective actions were documented against each adverse comment and reviewed

		quarterly. Several quality improvement activities are documented and relates to an improved food service, an improved varied activities programme, reduction of urinary tract infections (UTIs), reductions in pressure injuries, elimination of restraint. Three of the projects related to management and reduction of pressure injuries, reduction of UTIs and elimination of restraint has been achieved. The monitoring of the activities are ongoing. The resident management system provides 'real-time' benchmarking data against industry standards. Data is also analysed internally to identify areas for improvement. Quality data and trends in data are posted on a quality noticeboard. A hazard and risk management plan is in place. Health and safety meetings occur bimonthly. Actual and potential risks are documented in a hazard register, which identifies risk ratings, and documents actions to eliminate or minimise each risk. Staff incident, hazards, and risk information is collated at facility level, and is reported to the quality meeting. Electronic reports using an electronic resident management system are completed for each incident/accident, has a severity risk rating, and immediate action is documented with any follow-up action(s) required, evidenced in the accident/incident forms reviewed. There is a process for following the Adverse Event Reporting Policy. Management demonstrated an understanding and are compliant with statutory and regulatory obligations in relation to essential notification reporting. There have been notifications sent to the Health Quality and Safety Commission (HQSM) related to falls and Section 31 notifications reported as required. The change in management has been reported at the time of change to HealthCERT. There have been two outbreaks reported to Public Health and HealthCERT since the previous audit.
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.	FA	There is a staffing policy that guides clinical staffing ratios to meet the acuity needs of residents. The roster provides sufficient and appropriate cover for the effective delivery of clinically safe care and support to residents. There is 24/7 RN cover: with at least five RNs on morning and three RNs on afternoon shift. Since the previous audit, the registered

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.		nurse hours for the dementia unit and rest home have increased. There is one RN allocated to the dementia unit in the morning and afternoon, supported by the dementia unit clinical coordinator. The roster is developed with a pattern whereby the facility is overseen over weekends by a clinical coordinator (rest home and hospital). Caregivers reported that staffing is adequate to meet the needs of the residents but also to reflect acuity of residents and the physical layout of the facility. The roster reviewed was fully covered and backfilled when staff were absent on short notice. Residents and family/whānau interviewed confirmed their care requirements are attended to in a timely manner. Meeting minutes evidence staff and residents are informed when staffing levels change. In the absence of the care facility manager, the clinical manager or general manager will oversee the service. The three clinical coordinators and clinical manager share the on-call roster. There are separate staff allocated to the kitchen, laundry, recreation, cleaning and maintenance activities. There is an annual education and training schedule being implemented. The education and training schedule lists compulsory training which includes cultural awareness training. This includes staff completing a cultural competency. An education coordinator (interviewed) coordinates the orientation, training schedule, competencies, individual training records, and attendance. Compulsory training also includes topics relevant to the conditions of the residents. All caregivers and RNs (100% attendance) completed training in assessing change in resident`s condition and how to respond to falls in 2025 and the topics are rescheduled to be completed by end of March 2026 with a current completion rate of 38%. Managing staff skill gap is a goal in the business plan. The service supports and encourages caregivers to obtain a New Zealand Qualification Authority (NZQA) qualification. Sixty-six caregivers are employed and 53 hold the national Certificate in Health and Wellbeing level three or above. Lady Wigram Village supports all employees to transition through the NZQA Certificate in Health and Wellbeing. There are 18 caregivers who work in the dementia unit. Fourteen have completed the required training to meet ARRC E 4.5(f). Four caregivers

		are in the process of completing the training within the required timeframe. There is a Careerforce assessor, working two days a week. A training policy is being implemented. All staff are required to complete competency assessments as part of their orientation. Additional RN specific competencies include subcutaneous fluids, syringe driver and interRAI assessment competency. All RNs have attended in-service training around critical thinking. There are 24 registered nurses (RNs), and 20 are interRAI trained. Registered nurses are supported to attend external learning opportunities. A selection of caregivers completes annual medication administration competencies, wound competencies and competencies to complete neurological observations. A record of completion is maintained on an electronic human resources system. All competencies have been completed as scheduled.
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	Nine staff files reviewed included evidence of completed training and competencies and professional qualifications on file where required. There are job descriptions in place for all positions that include outcomes, accountability, responsibilities, authority, and functions to be achieved in each position. A register of practising certificates is maintained for all health professionals. The service has a role-specific orientation and induction programme in place that provides new staff with relevant information for safe work practice and includes buddying on commencement. Competencies are completed as part of orientation, and the orientation programmes includes dementia-specific content for staff working in the dementia unit to support safe practice in accordance with dementia care requirements. Staff employed for one year or more have a current performance appraisal on file. Performance review processes include discussion of role responsibilities and competencies relevant to dementia care for staff working in the dementia unit.
Subsection 3.2: My pathway to wellbeing	FA	Eight resident files were reviewed: two dementia, three hospital, and three

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.		rest home level residents, including one resident receiving rest home level care on a respite contract. The registered nurses are responsible for residents' assessments, care planning, and evaluation of care. Care plans are developed using data collected during the initial nursing assessments, which include dietary needs, pressure injury risk, falls risk, social history, and information from pre-entry assessments. All residents, except the resident on respite care, had an interRAI assessment completed. This was supported by a full suite of assessments within the electronic resident management system, including assessments for skin integrity, pressure injury risk, dietary requirements, communication needs, and emotional, psychological, and behavioural support needs. The resident on respite had a full suite of assessments completed soon after admission and reviewed as required according to health needs. Assessments include (but are not limited to) falls risk, pressure injury risk, pain, mobility, cognition, behaviour, nutrition, and cultural and spiritual needs. The long-term care plans were comprehensive, individualised, and promoted resident independence. Initial assessments and long-term care plans were completed within 24 hours of admission and detailed residents' needs and preferences. Individualised long-term care plans (LTCP) are developed using information gathered during the initial assessments and the interRAI assessment. All sampled LTCPs and interRAI assessments had been completed within three weeks of residents' admission to the facility. Care plans for residents receiving dementia level care reflected a comprehensive 24-hour approach that incorporated each resident's usual routines, preferences, and behavioural support needs. Individualised interventions were documented to guide caregivers in responding to behaviours of concern and supporting residents using consistent, person-centred approaches. Behaviour monitoring charts and behaviour assessments are implemented for residents where required, including for residents receiving dementia level care. These tools form part of the ongoing assessment and care planning process, enabling staff to identify patterns, triggers, and contributing factors associated with behaviours of concern, and to evaluate the effectiveness of interventions to support consistent, person-centred care. Documented interventions and early warning signs

		reflected residents' assessed needs and were sufficiently detailed to guide care staff in the delivery of care. Short-term care plans (STCP) are developed for acute conditions, such as infections, wounds, and weight loss. Where ongoing management is required, interventions are incorporated into the LTCP to ensure continuity of care. Resident care is evaluated each shift and reported during handover and documented in the progress notes. Any change in a resident's condition is reported to the registered nurse. LTCPs were formally evaluated every six months in conjunction with interRAI reassessments or when there was a change in a resident's condition. Evaluations are documented by a registered nurse and include the degree of achievement towards identified goals and outcomes. Residents interviewed confirmed that assessments were completed according to their assessed needs and undertaken in the privacy of their bedrooms. There was evidence of family/whānau involvement in care planning, with documented ongoing communication regarding residents' health status. Family/whānau interviewed confirmed they are invited to multidisciplinary meetings to discuss the resident's care and provide input into care planning. They also confirmed they are kept informed of any changes in the resident's health status and management. Where family/whānau are unable to attend these meetings, they are provided with a copy of the care plan and informed of any changes made to the resident's care and management. The service has contracted an aged residential care general practice to provide medical services. A general practitioner (GP) and nurse practitioner (NP) visit the facility weekly on separate days. A GP is available after hours to provide clinical advice for residents with complex needs. Ambulance services are accessed to facilitate hospital transfer in medical emergencies. The initial medical assessment is undertaken by the GP or NP within the required timeframe following admission. Residents receive ongoing medical reviews every three months and when there is a change in their health status. Medical documentation and records reviewed were current and maintained in the resident management system. The GP interviewed stated that the facility operates to a high standard and is proactive in seeking medical support when required. This initiative includes meeting with residents and family/whānau within the first month of admission to support understanding of the

		transition into residential care and to establish shared goals of care. This occurs in addition to the communication and care planning expectations outlined in the ARRC contract. Additional meetings are arranged with residents and family/whānau who require further support or clarification regarding care planning and expectations. A physiotherapist is contracted to visit weekly and reviews residents referred by registered nurses as required. There is access to continence and palliative care specialists as required. A podiatrist visits regularly. A dietitian, speech language therapist, wound care nurse specialist, and other medical specialists are available as required through Health New Zealand. An adequate supply of wound care products was sighted at the facility. A review of wound care plans evidenced that wounds were assessed in a timely manner with appropriate management plans and regular review. Photographs were taken where required. Where wounds required additional specialist input, referrals were initiated and a wound care nurse specialist was consulted. The wound register recorded thirty-seven active wounds at the time of the audit. Wound types included skin tears, ulcers, lesions, abrasions, lacerations, and other minor traumatic wounds. Progress notes are recorded and maintained within the integrated clinical records. Monthly observations, such as weight and blood pressure, were completed and up to date. Neurological observations are recorded following unwitnessed falls in accordance with policy. Staff interviews confirmed they were familiar with residents' needs and had access to the supplies and products required to meet those needs. Staff receive handover at the beginning of each shift.
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	FA	Policies and procedures are in place for safe medication management and meet legislative requirements. All staff who administer medications have completed annual medication competencies. Education on safe medication administration is provided as part of the competency process. Registered nurses have completed syringe driver training. Staff were observed to administer medications safely during the audit. Registered nurses and medication competent caregivers interviewed were able to describe their roles and responsibilities in relation to medication

practice guidelines.		administration. The service utilises an electronic medication management system, and medications are supplied by the pharmacy in blister packs for regular use and as required medications. Three monthly medication reviews were evidenced through GP/NP documentation, resident progress notes within the resident electronic management system, and interviews with residents and family/whānau, registered nurses. All medications are checked on delivery against the medication chart, and any discrepancies are reported to the supplying pharmacy. Medications were appropriately stored in designated medication rooms located on each floor. Medication room and medication fridge temperatures are monitored daily and records show that the temperatures are with required range. Stored medications are checked weekly, with a six-monthly pharmacy audit undertaken. Eyedrops were dated on opening. Sixteen medication charts were reviewed. Each medication chart included photo identification and allergy status. Indications for use were documented for pro re nata (PRN) medications, including over-the-counter medications and supplements. The effectiveness of pro re nata (PRN) medications was consistently documented in the resident progress notes. Four residents were self-administering medications. The service policy and procedures for assessing resident competency had been followed, and safe storage arrangements were in place. No vaccines are stored on site, and no standing orders are used.
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	There is a verified food control plan. The kitchen receives resident dietary forms on admission and is notified of any dietary changes for residents. Food preferences and cultural preferences are encompassed into the menu. Dislikes and special dietary requirements are accommodated, including food allergies. The kitchen manager interviewed reported they accommodate residents' requests. The residents and family/whānau interviewed were complimentary regarding the standard of food provided.

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 support.	FA	There were documented policies and procedures to ensure discharging or transferring residents have a documented transition, transfer, or discharge plan, which includes current needs and risk mitigation. Planned discharges or transfers were coordinated in collaboration with the resident (where appropriate), family/whānau and other service providers to ensure continuity of care.
Subsection 4.1: The facility The people: I feel the environment is designed in a way that is safe and is sensitive to my needs. I am able to enter, exit, and move around the environment freely and safely. Te Tiriti: The environment and setting are designed to be Māori-centred and culturally safe for Māori and whānau. As service providers: Our physical environment is safe, well maintained, tidy, and comfortable and accessible, and the people we deliver services to can move independently and freely throughout. The physical environment optimises people's sense of belonging, independence, interaction, and function.	FA	The building warrant of fitness is current. Buildings, plant, and equipment are fit for purpose and comply with legislation relevant to the health and disability services being provided. The environment is inclusive of people's cultures and supports cultural practices. The property manager is responsible for maintaining the buildings and grounds and for overseeing implementation of the annual maintenance plan. This includes electrical testing and tagging, equipment checks, call bell checks, calibration of medical equipment, and monthly testing of hot water temperatures. Documentation sighted and reviewed with the maintenance manager evidenced completion of the tests and monitoring required under the annual maintenance plan.
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.	FA	There is an infection, prevention, and antimicrobial policies and procedures that includes the pandemic plan. The infection prevention and control and antimicrobial stewardship programme is reviewed annually with input from the Infection Control Coordinator, who has completed infection control training and provides specialist oversight of infection control policies and procedures. The programme is linked to the quality

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.		improvement programme and is also approved by the executive team. The pandemic plan is available for all staff. Staff education includes standard precautions; isolation procedures; hand washing competencies; and donning and doffing of personal protective equipment (PPE). All staff have completed the required training within the last 12 months. Infection prevention education is coordinated and delivered by the Infection Control Coordinator (clinical coordinator) and is included in staff orientation, with annual mandatory updates relevant to the service, including hand hygiene, standard precautions, and use of personal protective equipment.
Subsection 5.4: Surveillance of health care-associated infection (HAI) The people: My health and progress are monitored as part of the surveillance programme. Te Tiriti: Surveillance is culturally safe and monitored by ethnicity. As service providers: We carry out surveillance of HAIs and multi-drug-resistant organisms in accordance with national and regional surveillance programmes, agreed objectives, priorities, and methods specified in the infection prevention programme, and with an equity focus.	FA	The antimicrobial policy aims to provide a quality review of the incidents of infections, reduce the rate of infections within the facility, and reinforce basic principles of infection prevention and control. Infection surveillance processes are documented in the infection control policy and include standardised definitions. Infection surveillance is the responsibility of the infection control coordinator. All infections are entered into the electronic resident system, with a monthly collation and analysis of infections completed by the infection control coordinator. Any trends are identified, and corrective actions implemented. The service incorporates ethnicity data into surveillance methods and data captured around infections. Results of infection surveillance, including identified trends, outcomes, and corrective actions, are documented however, there was limited evidence that these are reported through quality meetings and shared with staff (link 2.2.2). There was evidence of robust debrief meetings held during outbreaks. The executive meeting minutes reviewed evidence significant events and debrief with governance oversight. Internal infection control audits are completed with corrective actions put in place when areas of improvement are identified. The service receives regular notifications from Health New Zealand. There have been two outbreaks (Covid 19 in August 2025; gastroenteritis [Norovirus and Yersiniosis]) November 2025-January 2026 since the previous audit. The outbreaks were documented, appropriately managed,

		and reported to relevant authorities. Debrief meetings occurred during and following the outbreaks as evidenced in staff meeting minutes sighted.
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 governance body demonstrates a commitment to restraint elimination. All restraint use has been eliminated since March 2025. The restraint coordinator is one of the hospital registered nurses. The restraint coordinator described the service's focus on ensuring care is provided in the least restrictive manner possible. The restraint policy confirms that any consideration or application of restraint must occur in partnership with the resident and family/whānau, and that any device used must be the least restrictive option possible. Where restraint is considered, the service works in partnership with the resident and family/whānau to ensure care remains mana enhancing. The service works in partnership with Māori to promote and ensure services are mana enhancing. At the time of the audit, there were no residents using restraint. Restraint elimination is included in the mandatory training plan and orientation programme.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 2.2.2 Service providers shall develop and implement a quality management framework using a risk-based approach to improve service delivery and care.	PA Low	There is an annual meeting schedule that includes monthly quality improvement, bimonthly health and safety, bimonthly staff, monthly RN/clinical and quarterly resident meetings. The quality meetings provide an avenue for discussions in relation to (but not limited to): infection control; complaints received (if any); staffing; education; quality data; health and safety; hazards; service improvement plans; incidents and accidents; internal audits; and infections. All agenda items, discussion points and actions have been evidenced as being followed up or completed. The infection control coordinator and clinical manager states the infection control committee is also the quality committee and infections are presented and discussed at the monthly quality meetings. Although infection surveillance and antimicrobial stewardship (AMS) is a set agenda item in the quality meeting minutes; there were limited evidence of discussions in the meeting	Quality meetings did not always include discussions related to infections surveillance data, ethnicity, trends and analysis including AMS activities.	Ensure quality meetings include all aspects of the quality and risk programme. 90 days

		minutes (from August 2025 year to date). Staff stated they are informed of infection control related issues through handover, regular debrief meetings during outbreaks and meeting minutes sent to them through the internal communication system.		

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.