Sunflower Field NZ Limited - Summerville Rest Home

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:	Sunflower Field NZ Limited
Premises audited:	Summerville Rest Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 26 March 2026 End date: 27 March 2026

Proposed changes to current services (if any): The Manatū Hauora (the Ministry of Health) has requested the auditor review two resident bedrooms that the provider wishes to have certified as double rooms. On observation of these bedrooms, it was evident one bedroom was suitable for double occupancy, and one was too small. Both rooms were single occupancy at time of audit. The proposed reconfiguration of an additional six bedrooms, and the addition of another wing had not progressed at time of this surveillance audit.

Total beds occupied across all premises included in the audit on the first day of the audit: 15

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

Summerville Rest Home is certified to provide rest home level of care for up to 15 residents. On the day of audit there were 15 residents.

This surveillance audit was conducted against a subset of the Ngā Paerewa Health and Disability Services Standard 2021 and the funding agreements with Health New Zealand. The audit process included the review of policies and procedures, the review of resident and staff records, observations, and interviews with residents, family/whānau, management, staff and a nurse practitioner.

The service is managed by an owner/manager supported by the clinical manager. Feedback from residents and family/whānau was positive about the care provided.

The previous shortfalls identified pertaining to meeting minutes, and emergency management have been closed.

The shortfalls from the previous audit relating to complaints management, business plans, policies and procedures, police vetting, position descriptions, performance appraisals, entry criteria, ethnicity data, and the activities programme, remain open.

Shortfalls were identified at this surveillance audit pertaining to resident rights, quality and risk systems, staff training, resident care plans, medication management, nutrition, maintenance, and restraint.

The Ministry of Health – Manatū Hauora (the Ministry) has requested follow up on the providers progress on recommendations from a closed complaint investigated by the Office of the Health and Disability Commissioner in relation to resident rights, informed consent, falls policy and procedure, and care plans.

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 partially attained and of medium or high risk and/or unattained and of low risk.

There is a Māori health plan in place. The service recognises Māori mana Motuhake, and this is reflected in the Māori health plan. A Pacific health plan is in place which ensures cultural safety for Pacific peoples embracing their worldviews, cultural, and spiritual beliefs. Residents are informed of their rights.

Hunga mahi me te hanganga | Workforce and structure

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

Quality improvement projects are implemented. Internal audits are documented as taking place as scheduled with corrective actions as indicated.

Ngā huarahi ki te oranga | Pathways to wellbeing

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

The clinical manager and enrolled nurse are responsible for the planning and review of residents' needs, outcomes, and goals with the resident and/or family whānau input. Care plans demonstrate service integration. Resident records included medical notes by the contracted nurse practitioner, general practitioner and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. The electronic medicine charts reviewed met prescribing requirements.

The kitchen staff cater to individual cultural and dietary requirements.

All resident's 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.		Some subsections applicable to this service partially attained and of low risk.

The environment is inclusive of peoples' culture and supports cultural practices. The residents confirmed the facility provides a homelike atmosphere. There have been no changes to the facility since the last audit.

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

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

Infection prevention management systems are in place to minimise the risk of infection to residents and visitors. The infection prevention programme is implemented and meets the needs of the organisation and provides information and resources for staff. Documentation evidenced that relevant infection prevention education is provided to staff as part of their orientation and as part of ongoing in-service education programme.

Surveillance data is undertaken, including the use of standardised surveillance definitions. Results of surveillance are acted upon, evaluated, and reported to relevant personnel in a timely manner. Surveillance information is used to identify opportunities for improvements.

There has been an outbreak since the previous 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.		Some subsections applicable to this service partially attained and of low risk.

The service aims for a restraint free service. There has been no form of restraint used in the facility for some years now.

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	7	0	3	11	0	0
Criteria	0	31	0	3	22	0	0

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

Attainment against the Ngā paerewa Health and disability services standard

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

For more information on the standard, please click here.

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

Subsection with desired outcome	Attainment Rating	Audit Evidence
Subsection 1.1: Pae ora healthy futures Te Tiriti: Māori flourish and thrive in an environment that enables good health and wellbeing. As service providers: We work collaboratively to embrace, support, and encourage a Māori worldview of health and provide high-quality, equitable, and effective services for Māori framed by Te Tiriti o Waitangi.	FA	A Māori health plan is documented for the service which Summerville Rest Home utilise as part of their strategy to embed and enact Te Tiriti o Waitangi in all aspects of service delivery. At time of audit there were residents who identified as Māori. The cultural component of care plans reviewed provided evidence of how mana Motuhake is recognised and care provided is based upon the principles of Te Tiriti o Waitangi. Staff outlined how services were delivered in a culturally supportive manner and how Māori residents were supported within the environment.
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	Summerville Rest Home uses a model of care that reflects the values and beliefs which underpin the health service provision to Pacific people. At time of audit there were no residents residing in the facility who identified as Pasifika. Staff who identified as Pasifika were employed at time of audit. Staff confirmed an awareness of and understanding of Pacific culture, values, beliefs and were knowledgeable about how to access community support for Pasifika residents when required.

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 posters. All staff interviewed (the clinical manager, three caregivers, one enrolled nurse, and one cook), confirmed their knowledge of their responsibilities in relation to the Code. The residents interviewed (three) understood 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.	PA Moderate	There service has policy and procedure in place to guide staff to ensure residents are free from discrimination, coercion, harassment, physical or other exploitation, abuse or neglect. The policy aligns with Ngā Paerewa Health and Disability Services Standards (NZS8134) 2021. The service has a policy in place to safely manage residents comfort funds but at time of audit this not required as residents were independently managing their finances, or their enduring power of attorney (EPOA) had responsibility for this. Residents interviewed confirmed they believed their property was respected. Review of staff records, training records and discussion with staff evidenced that the process in place to arm staff with sufficient knowledge to maintain professional boundaries requires improvement.
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	FA	The clinical manager outlined the process in place that ensures that resident's family/whānau are included in decision making with the residents and are enabled to do so through access to quality information advice and resources. The clinical manager confirmed their understanding of the organisational process to ensure informed consent for all residents (including Māori, who may wish to involve whānau for collective decision making). Resident files reviewed included general consent forms and consents for influenza vaccinations. Consent forms were appropriately signed by the

legal representatives with the information necessary to make informed decisions in accordance with their rights and their ability to exercise independence, choice, and control.		EPOA where this has been activated. All documentation regarding EPOA and activation is on file.
Subsection 1.8: I have the right to complain The people: I feel it is easy to make a complaint. When I complain I am taken seriously and receive a timely response. Te Tiriti: Māori and whānau are at the centre of the health and disability system, as active partners in improving the system and their care and support. As service providers: We have a fair, transparent, and equitable system in place to easily receive and resolve or escalate complaints in a manner that leads to quality improvement.	PA Moderate	The complaints procedure is provided to residents upon entry to the service. There have been two internal complaints received since the previous audit, one complaint raised two issues and the other complaint received raised a separate issue. There were no trends identified. For all complaints there is limited documentation to evidence investigation, communication and resolution of the issues raised and all were still open at time of audit. A complaint received by the Office of the Health and Disability Commissioner (HDC) in May 2025 has been investigated and closed. However, the Ministry of Health – Manatū Hauora (the Ministry) requested the Designated Auditing Agency follow up on progress of the HDC complaint outcome recommendations, specifically; Subsection 1.5 I am protected from abuse – criterion 1.5.3; Resident's property and finances will be respected; Subsection 1.7 I am informed and able to make decisions – criterion 1.7.4; Family shall be included in the decision making and informed of any change in the residents condition; Subsection 2.2 Quality and Risk – criterion 2.2.2 Falls policy is adequate and guided by the Health Quality and Safety Commission (HQSC) frailty care guide; Subsection 3.2 My pathway to wellbeing – criterion 3.2.5 where the resident's condition changes this is appropriately documented in the progress notes and reflected in the care plan. This audit did not identify any specific issues relating to residents' property and finance but did evidence a lack of education around professional boundaries (link 1.5.4). There were no issues identified related to decision making, but aspects of communication to family were lacking (link 2.2.2).The falls policy was noted to comply with the HQSC frailty guides, but gaps in adverse event reporting were noted (link 2.2.2) This audit identified that although initial assessments and long-term care plans were completed within required timeframes, there were gaps identified in short term care planning, and timeliness of reviewing care planning when support needs changed (link 3.2.5).

		Residents have complained to management via their resident meetings about the standard of the evening meal. The feedback was documented within the meeting minutes and the corrective action put in place to address the issues. Residents interviewed stated the evening meal has improved. Residents and family/whānau (one) interviewed confirmed they are aware of the complaints process. Complaint forms are located at the entrance and in visible places throughout the facility or on request from staff. Residents or relatives making a complaint can involve an independent support person in the process if they choose. The Code of Health and Disability Services Consumers' Rights and complaints process is visible, and available in te reo Māori, and English. Information about the support resources for Māori is available to staff to assist Māori in the complaints process. Interpreters contact details are available. The clinical manager acknowledged their understanding that for Māori, there is preference for face-to-face communication and to include whānau. The shortfall identified at the previous audit remains open.
Subsection 2.1: Governance The people: I trust the people governing the service to have the knowledge, integrity, and ability to empower the communities they serve. Te Tiriti: Honouring Te Tiriti, Māori participate in governance in partnership, experiencing meaningful inclusion on all governance bodies and having substantive input into organisational operational policies. As service providers: Our governance body is accountable for delivering a highquality service that is responsive, inclusive, and sensitive to the cultural diversity of communities we serve.	PA Moderate	Summerville Rest Home is an aged care facility in Hastings owned by Sunflower Field New Zealand Limited. The service is certified to provide rest home level care for up to 15 residents. At the time of audit there were 15 residents including one younger person with disability (YPD). The remaining residents were on the age-related residential care ARRC contract. There has been no change in management since the previous audit as outlined by the clinical manager. The owner/manager was overseas at time of audit and was unable to be contacted. The owner/manager has owned the facility since 2015. The clinical manager is supported by a team of care and support staff. The governance of the company is led by the owner/manager. In the absence of the owner/manager information available confirmed there was no evidence to suggest that the company is not meeting their compliance with legislative, contractual, and regulatory requirements.

		The vision and values are posted in visible locations throughout the facility. In the absence of the owner/manager the business plan could not be sighted. Review of information that was available evidenced that the owner/manager is committed to the quality and risk management system. The clinical manager is in frequent contact with the owner/manager on an ad hoc basis where recent resident and staff events are discussed. Information was provided that validated how Summerville Rest Home delivers services that improve outcomes and achieves equity for Māori. The service identifies external and internal risks and opportunities that include identifying any barriers to Māori and service delivered is equitable. Clinical governance is led by the clinical manager with support from the enrolled nurse. There are weekly updates given at handover and these talks focus on current clinical focus areas. The shortfall identified at the previous audit remains open.
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	Summerville Rest Home has a quality and risk management programme in place. However not all aspects of this were implemented at time of audit. The quality and risk management systems include performance monitoring through internal audits and through collection of clinical data. Not all policies and procedures were available at time of audit and progress made regarding whether they align with Ngā Paerewa Health and Disability Services Standards (NZS8134:2021) was unable to be verified. The clinical manager leads and implements the quality programme. The quality programme involves all staff with every staff member expected to be active in implementing a quality approach when at work and participating in the quality programme. Post fall management policy and procedures have been implemented as a recommendation from the HDC complaint. This document was based upon the Health Quality Safety Commission (HQSC) frailty guides and provides staff with the correct processes to initiate following a resident fall. However, this was

		inconsistently followed in resident incident/accident events reviewed. Not every event involving a resident reflected a clinical assessment and follow up by a registered nurse. Opportunities to minimise future risks were not always identified. Relatives are not always informed following incidents. Not all events are collated, analysed and shared with staff. Monthly staff, and clinical/quality, meetings provide an avenue for discussions that include health and safety, staffing and infection prevention. Meeting minutes sighted evidenced that meetings are occurring as scheduled. Meeting minutes reviewed confirmed key components of service delivery are addressed. Resident family/whānau meetings are occurring as per schedule with resident's interviewed stating they find the meetings helpful to find out what is happening within the home and have an opportunity to give feedback. Residents confirmed when they raised dissatisfaction with the evening meals via the resident meeting forum the problems were addressed and they were involved in this. The last resident and family/whānau satisfaction survey results were completed in 2024. A health and safety system is in place. Hazard identification forms are completed, and the hazard register was in the process of being updated. Staff have completed training related to health and safety. Staff are kept informed on health and safety issues through the handover process and staff meetings. The clinical manager was unsure of the requirement to notify relevant authorities in relation to essential notifications or whose responsibility it was in the absence of the owner/manager. No S31 notification was completed for the recent nationwide outage of the electronic medication system which impacted the service. Not all policies and procedures were made available to the auditor and the shortfall identified at the previous audit remains open. Review of documentation including meeting minutes, discussion with management and staff, interview with residents and family whānau confirmed that all meetings were addressing key components of service delivery. The previous shortfall identified at the previous audit is closed.
Subsection 2.3: Service management	PA	Review of the current and previous rosters evidenced that appropriate staff were always rostered on duty to meet the service contractual

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	requirements. Planned and unplanned staff absences were consistently covered. The owner/manager is overseas and when in New Zealand they come to Summerville Rest Home once a month. There was no formal plan put in place whilst the owner/manager is overseas, and the clinical manager was unsure of some aspects of their role in their absence. (Link 2.2.5). Currently the clinical manager works full time Monday to Friday and is providing 24/7 support for all clinical and operational issues. The enrolled nurse provides cover in their absence. Separate cleaning staff are rostered. The caregivers perform laundry duties across all three shifts. Staff on duty on the days of the audit were visible attending to resident's needs. Staff and residents confirmed that call bells are rarely activated. Staff interviewed stated that the staffing levels are adequate for the resident needs however there was no consensus on management support or teamwork. Residents and family/whānau member interviewed reported that they believe that staff numbers were adequate. Review of documentation and discussion with staff evidenced a training is occurring however this is ad hoc. Staff training that has been delivered includes post fall management, family communication, first aid, privacy, infection prevention, resident rights, however the training programme delivered is incomplete and requires improvement. It was not possible to verify if the annual training programme exceeds 8 hours annually. There is an attendance register for each training session however this is yet to be included within each staff members personal file. All care staff are encouraged to complete New Zealand Qualification Authority (NZQA) qualifications. Care staff have either completed, commenced or are due to commence a New Zealand Qualification Authority education programme to meet the providers funding and service agreement requirements. The clinical manager and enrolled nurse maintain their professional competency. At the time of audit, the clinical manager and enrolled nurse have completed interRAI training. The clinical manager has current competency with syringe driver management.

Subsection 2.4: Health care and support workers The people: People providing my support have knowledge, skills, values, and attitudes that align with my needs. A diverse mix of people in adequate numbers meet my needs. Te Tiriti: Service providers actively recruit and retain a Māori health workforce and invest in building and maintaining their capacity and capability to deliver health care that meets the needs of Māori. As service providers: We have sufficient health care and support workers who are skilled and qualified to provide clinically and culturally safe, respectful, quality care and services.	PA Moderate	Five staff records were reviewed. All records were incomplete with gaps evident pertaining to training, competencies, and pre-employment documentation. There was no evidence that police vetting was undertaken, job descriptions were not included in the staff record and could not be located elsewhere, and no documentation was complete that evidenced all staff have an appraisal after a year or more of employment. Professional qualifications are validated prior to employment, and a register is maintained to ensure staff currency thereafter. A register of practising certificates is maintained for all health professionals. The service has implemented a role-specific orientation programme in place that provides new staff with relevant information for safe work practice and includes buddying when first employed. Staff interviewed advised they thought the orientation was basic but adequate. The shortfall identified at the previous audit remains open.
Subsection 3.1: Entry and declining entry The people: Service providers clearly communicate access, timeframes, and costs of accessing services, so that I can choose the most appropriate service provider to meet my needs. Te Tiriti: Service providers work proactively to eliminate inequities between Māori and non-Māori by ensuring fair access to quality care. As service providers: When people enter our service, we adopt a person-centred and whānau-centred approach to their care. We focus on their needs and goals and encourage input from whānau. Where we are unable to meet these needs, adequate information about the reasons for this decision is documented and communicated to the person and whānau.	PA Moderate	Discussion with the clinical manager and review of documentation evidenced there is no process in place that ensures the resident entry criteria is clearly communicated to people, their family/whānau, local communities, and referral agencies. Discussion with the clinical manager and review of documentation evidenced that the provider is yet to implement a system that collates and analyses ethnicity data in relation to entry and decline rates. The shortfall identified at the previous audit remain open.
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.	PA Moderate	Five resident records were reviewed. The clinical manager and the enrolled nurse are responsible for all resident's assessments, care planning and evaluation of care. All initial assessments and long-term care plans were completed for residents, detailing needs, and preferences. However, the current system in place to ensure these

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.		documents are updated within required timeframes requires improvement. The individualised electronic long term care plans (LTCPs) are developed with information gathered during the initial assessments and the interRAI assessment. All LTCPs and interRAI sampled had been completed within three weeks of the residents' admission to the facility however updates for these documents did not always meet timeframes required. The resident identified as being under the YPD contract was not required to have an interRAI assessment however they had an assessment completed including falls risk, communication (verbal and non-verbal), continence, mobility, and nutrition. Interventions and early warning signs (EWS) to meet the residents' assessed needs were inconsistently updated as care needs changed and care staff were not always provided with sufficient guidance and interventions required to meet the resident's needs. The activity assessments include a cultural assessment which gathers information about cultural needs, values, and beliefs (link 3.3.1). However, in the absence of an activities coordinator this information was inconsistently used to develop the resident's individual activity care plan. Short term care plans (STCPs) are not always developed for acute problems, for example infections, wounds, behaviour changes and weight loss. Resident care is evaluated on each shift and reported at handover and in the progress notes. Long-term care plans are not always formally evaluated every six months in conjunction with the interRAI re-assessments and when there is a change in the resident's condition. Evaluations are not always documented or include the degree of achievement towards meeting the desired goals and outcomes. Residents interviewed confirmed assessments are completed according to their needs and are undertaken in the privacy. Resident records evidenced that family/whānau are not always informed where there is a change in health status (Link 2.2.2). The initial medical assessment is undertaken by the general practitioner or nurse practitioner within the required timeframe following admission. Residents have ongoing reviews by the nurse practitioner and general practitioner within required timeframes and when their health status

		changes. There is one nurse practitioner (who oversees the medical care for most residents) and visits weekly and as required. The remaining residents have maintained their own general practitioner. When interviewed the nurse practitioner advised that communication from the service was not always timely regarding residents change of health status. After hours care is provided by the contracted medical practice and the local public hospital when needed. If a physiotherapist is required a referral is completed, however accessing physiotherapist currently through the public system can result in a wait time. A nail pedicurist attends to residents needs whilst a podiatrist is accessed for the service. Other health professionals are available by referral when required. An adequate supply of wound care products was available at the facility. Discussion with the clinical manager and review of documentation evidenced there was one current wound which was minor in nature. The wound had been regularly dressed, evaluated and photos had been taken capturing the progress. However, a STCP had not been created for this. Where wounds require additional specialist input a wound nurse specialist is consulted. The progress notes are recorded and maintained in the integrated records. A range of monitoring charts are available for care staff including monthly observations such as weight and blood pressure. All files reviewed evidenced these were completed and were up to date. Neurological observations were inconsistently recorded following un-witnessed falls. Staff interviews confirmed they are familiar with the needs of all residents in the facility and that they have access to the supplies and products they require to meet those needs. Staff receive a written and verbal handover (witnessed) at the beginning of each shift.
Subsection 3.3: Individualised activities The people: I participate in what matters to me in a way that I like. Te Tiriti: Service providers support Māori community initiatives and activities that promote whanaungatanga.	PA Moderate	At time of audit the owner/manager had not recruited a diversional therapist or activities coordinator. A care giver has been tasked with spending one hour a day Monday to Friday to carry out an activity programme. The caregiver is not trained, and they do not follow an approved activity programme. This task takes them away from resident

As service providers: We support the people using our services to maintain and develop their interests and participate in meaningful community and social activities, planned and unplanned, which are suitable for their age and stage and are satisfying to them.		cares and cannot always be implemented due to resident needs on the day. The shortfall identified at the previous audit remains open.
Subsection 3.4: My medication The people: I receive my medication and blood products in a safe and timely manner. Te Tiriti: Service providers shall support and advocate for Māori to access appropriate medication and blood products. As service providers: We ensure people receive their medication and blood products in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Moderate	There are policies available for safe medicine management that meet legislative requirements. Not all staff who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided as part of the competency process. The clinical manager has completed syringe driver training. Staff were observed to be safely administering medications. Medication competent caregivers interviewed could describe their role regarding medication administration. The service currently uses blister packs for medication. All medications are checked on delivery against the medication chart, and any discrepancies are fed back to the supplying pharmacy. Medications were noted to be inappropriately stored during period of audit. The medication fridge temperatures are monitored daily, and all stored medications are checked weekly. Eyedrops are dated on opening. Ten medication charts were reviewed. Each chart sampled had photo identification and allergy status identified. Indications for use were noted for as required medications, and the effectiveness of as required medication was documented in the resident's progress notes. There was one resident self-administering over the counter pain relief that had not been prescribed by the general practitioner or nurse practitioner. There was no pain assessment completed to ascertain why the resident was taking this. No vaccines are kept on site. There are no standing orders in use. There was documented evidence in the clinical files that residents and relatives are updated around medication changes, including the reason for changing medications and side effects. When medication related incidents occurred, these were investigated and followed up.

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.	PA Low	The menu has been changed in direct response to residents complaining about the poor standard of meals. A corrective action implemented by the clinical manager ensured the residents involvement in changes required to better meet their needs. Residents interviewed confirmed the standard of the meals has improved. The kitchen receives resident dietary information and is notified of any dietary changes for residents. Dislikes and special dietary requirements are accommodated, including food allergies. There was no evidence submitted that the facility has a food control plan.
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	Review of documentation and discussion with the clinical manager evidenced appropriate process is followed that ensures all discharging or transferring residents have a documented transition, transfer or discharge plan which includes risk mitigation. Planned discharges or transfers were coordinated in collaboration with the resident, 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	PA Low	The environment is inclusive of people's culture and supports cultural practices. The building warrant of fitness (BWOF) is current until January 2027. The building's plant and equipment are all showing significant signs of wear and tear. There was evidence of an annual maintenance plan that includes electrical testing and tagging, equipment checks, call bell checks, calibration of medical equipment and monthly testing of hot water temperatures was provided. Repairs are required in one resident bathroom. A contractor has been requested to fix the issue however the provider has been informed due to a high work load they are unable to estimate when this can be fixed.

belonging, independence, interaction, and function.		Meanwhile the bathroom can only be used by residents who are not cognitively impaired. There is no safety signage, no hazard identification documented. It was unable to be confirmed if essential contractors/tradespeople are available 24 hours per day as required.
Subsection 4.2: Security of people and workforce The people: I trust that if there is an emergency, my service provider will ensure I am safe. Te Tiriti: Service providers provide quality information on emergency and security arrangements to Māori and whānau. As service providers: We deliver care and support in a planned and safe way, including during an emergency or unexpected event.	FA	The provider has purchased a generator since the previous audit. The shortfall identified at the previous audit is now closed.
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	There are infection, prevention, and antimicrobial policies and procedures, and a pandemic plan. The programme and is approved by the owner/manager. The clinical manager leads the infection prevention programme. Policies were developed with input from infection prevention specialists, and these comply with relevant legislation and accepted best practice. The infection prevention programme is reviewed annually. The pandemic plan is available for all staff. The clinical manager is responsible for the implementation of staff education includes standard precautions; isolation procedures; hand washing competencies; and donning and doffing of personal protective equipment (PPE).
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-	PA Moderate	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. Infection surveillance is the responsibility of the infection prevention coordinator. All infections are documented within a hard copy infection register. There are a monthly collation and analysis of infections completed by the infection prevention coordinator. Any trends are identified, and corrective actions

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.		implemented. The service is yet to incorporate ethnicity data into surveillance methods and data captured around infections. Outcomes are discussed at handovers when residents have infections and at staff meetings. Staff have received infection prevention related training including outbreak management. Internal infection prevention audits are completed with corrective actions for areas of improvement. The service receives regular notifications from Health New Zealand. The infection prevention coordinator is part of the regional (Health New Zealand) infection prevention group and attends bimonthly meetings. The shortfall identified at the previous audit remains open.
Subsection 6.1: A process of restraint The people: I trust the service provider is committed to improving policies, systems, and processes to ensure I am free from restrictions. Te Tiriti: Service providers work in partnership with Māori to ensure services are mana enhancing and use least restrictive practices. As service providers: We demonstrate the rationale for the use of restraint in the context of aiming for elimination.	PA Low	Maintaining a restraint free environment is the aim of the service. Policies and procedures confirm the governing body's commitment to ensuring resident care is provided free from any form of restraint. The clinical manager is responsible for the restraint elimination strategy and for monitoring restraint use in the service. They maintain the restraint portfolio. Systems are in place to ensure restraint use will be reported to staff meetings, and to the owner/manager. Restraint policy confirms that restraint consideration and application must be done in partnership with residents and family/whānau and the choice of device must be the least restrictive possible. There was no evidence that restraint is included as part of the orientation for staff and completed annually through the education plan.

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 1.5.4 Health care and support workers shall maintain professional boundaries with me and refrain from acts or behaviours that could negatively impact on my wellbeing.	PA Moderate	Review of staff personal files, training records and discussion with staff evidenced that policy and process pertaining to staff employment require improvement to ensure staff have knowledge of professional boundaries and maintain residents’ safety.	Staff do not sign a code of conduct during their onboarding process, have training in or sign documents ensuring they are aware of professional boundaries and refrain from acts or behaviours that could impact negatively on residents’ wellbeing.	Ensure the onboarding process for all staff includes signing a code of conduct. 60 days
Criterion 1.8.3 My complaint shall be addressed and resolved in accordance with the Code of Health and Disability Services Consumers’ Rights.	PA Moderate	Residents and family/whānau interviewed were aware of the complaints process. Staff interviews and review of two complaints that raised a total of three separate issues evidenced that the process in place to adequately manage complaints requires improvement.	Two complaints did not evidence they had been investigated, that outcomes were clearly documented and the complaint could be closed to the satisfaction of the complaints. All complaints remain open at time of audit.	Ensure all complaints are addressed and resolved in accordance with the Code of Health and Disability Services Consumer’s Rights. 60 days

Criterion 1.8.4 I am informed of the findings of my complaint.	PA Moderate	Staff interview and review of information available for the two complaints received since the previous audit confirmed the complaints process requires improvement.	Review of three complaints did not evidence the complainant was satisfied with the outcome so the complaint could be closed.	Ensure complaints policy and process is implemented and followed and all complaints are only closed when the complainant is satisfied with the outcome. 60 days
Criterion 2.1.2 Governance bodies shall ensure service providers' structure, purpose, values, scope, direction, performance, and goals are clearly identified, monitored, reviewed, and evaluated at defined intervals.	PA Moderate	The provider had a business plan in place at the previous audit. However, due to the absence of the owner/manager the business plan could not be reviewed.	There was no evidence provided that validated that the goals documented in the business plan have been reviewed at regular intervals.	Ensure evidence is provided that the business plan is current and that the goals have been reviewed at regular intervals. 60 days
Criterion 2.2.2 Service providers shall develop and implement a quality management framework using a risk-based approach to improve service delivery and care.	PA Moderate	Since the previous audit some policies and procedures have been updated to reflect Ngā Paerewa NZS 8134:2021. However, on day of audit not all policies and procedures were made available to the auditor. Total progress made towards gaps identified at the previous audit were unable to be verified. Policy and procedure for post falls management are now in place following a recommendation outcome from the HDC complaint. This document is based upon the Health Safety Quality Commission	i) Not all policies and procedures were made available to the auditor and could not be verified that progress has been made, and the policies align with Ngā Paerewa NZS 8134:2021. ii) In one of two resident incident accident event forms reviewed (unwitnessed falls) next of kin had not been informed. iii) In two of four incident/accident events there was no follow up by the registered nurse. In addition, one behaviour event was documented in the resident's progress notes, but no related	i) Ensure all policies and procedures are reviewed and align with Ngā Paerewa Health and Disability Services Standards (NZS8134:2021). ii) Ensure all post fall management protocols are followed for all unwitnessed falls. iii) Ensure all resident incident/accidents are documented appropriately, followed up by a registered nurse, appropriate monitoring put in place where required, and changes made to care plans

		frailty care guide. However, incident accident forms reviewed were incompletely documented and require improvement.	incident form completed. There was no behaviour monitoring, or a short-term behaviour care plan put in place to guide staff in the appropriate interventions for the safe management residents and staff.	that reflect the change of care needs for the resident. 60 days
Criterion 2.2.4 Service providers shall identify external and internal risks and opportunities, including potential inequities, and develop a plan to respond to them.	PA Moderate	Through review of available documentation and discussion with the clinical manager it was evident the way in which the provider responds to internal and external risks requires improvement.	The provider has no process in place that enables identification of external and internal risks and opportunities, including potential inequities.	Ensure policy and procedure is implemented that guides staff in the identification of external and internal risks and develops a plan to respond to them. 60 days
Criterion 2.2.5 Service providers shall follow the National Adverse Event Reporting Policy for internal and external reporting (where required) to reduce preventable harm by supporting systems learnings.	PA Moderate	The clinical manager is taking overall responsibility for the day-to-day management of the facility in the absence of the owner/manager. However, no succession plan of responsibilities while the owner/manager is on leave was provided to the clinical manager. Review of documentation and discussion with the clinical manager highlighted lack of awareness of appropriately reporting serious events. This requires improvement.	The provider does not have policy and process in place that ensures the National Adverse Event Reporting Policy and Severity Assessment Code (SAC) reporting procedures are followed post all serious events to reduce preventable harm by supporting systems learnings. There is no plan in place that clearly outlines all the clinical managers responsibilities in the absence of the owner/manager.	Ensure policy and procedure are implemented and followed and all serious events are reported appropriately to guide improvements in care. Ensure a clear plan is in place in the absence of the owner/manager that ensures the day-to-day management of the facility is not interrupted. 60 days
Criterion 2.2.6 Service providers shall understand and comply with	PA Moderate	Review of documentation and discussion with the clinical manager confirmed they did not	The provider does not comply with statutory and regulatory obligations in relation to essential notification	Ensure the service develops and implements process that ensures they comply with their

statutory and regulatory obligations in relation to essential notification reporting.		understand the need to comply with statutory and regulatory obligations. A S31 notification was not completed when the services electronic medication management system was impacted by the nationwide outage earlier this year.	reporting.	obligations in relation to essential notifications. 90 days
Criterion 2.3.3 Service providers shall implement systems to determine and develop the competencies of health care and support workers to meet the needs of people equitably.	PA Moderate	Staff have completed infection prevention competencies, first aid training and most caregivers that complete medication administration are medication competent. However, discussion with staff and review of documentation evidenced that the system in place to determine and develop staff competencies requires improvement.	The provider is yet to develop and implement a system that ensures all staff have the required competencies to meet the needs of all people equitably.	Ensure a system is developed and implemented that ensures all staff have the required competencies to meet the needs of all people equitably. 90 days
Criterion 2.3.4 Service providers shall ensure there is a system to identify, plan, facilitate, and record ongoing learning and development for health care and support workers so that they can provide high-quality safe services.	PA Moderate	Staff training is occurring with key topics covered including post fall management, infection prevention, resident rights, privacy. However, an education schedule is yet to be fully implemented to provide staff with knowledge required to meet all resident's needs.	Review of five staff files and training records, and discussion with the clinical manager evidenced that a training schedule is yet to be implemented that covers mandatory/annual training appropriate to the service delivered.	Ensure a training programme is developed and implemented so that staff have the skills required to provide high quality safe services. 90 days
Criterion 2.4.1 Service providers shall develop and implement policies and procedures in accordance with	PA Moderate	The service provider had attempted to meet process required to adhere to good employment practice. However, five of five staff records were	Five out of five staff records did not evidence that police vetting was undertaken.	Ensure there is documented evidence of police vetting undertaken as part of the pre-employment process.

good employment practice and meet the requirements of legislation.		incomplete.		60 days
Criterion 2.4.2 Service providers shall ensure the skills and knowledge required of each position are identified and the outcomes, accountability, responsibilities, authority, and functions to be achieved in each position are documented.	PA Moderate	A folder was available on day of audit that contained the hard copy job descriptions that are to be completed for each staff member prior to commencing their employment. However, completed ones were not found for any staff member on day of audit.	Five of five staff records reviewed did not have a position description in place.	Provide evidence of signed position descriptions for all staff. 60 days
Criterion 2.4.5 Health care and support workers shall have the opportunity to discuss and review performance at defined intervals.	PA Moderate	Some staff files had appraisals on record however all documentation reviewed was incomplete.	Three of five staff files reviewed did not have an appraisal on record, two of five had an appraisal but it was not dated or signed by the staff member.	Ensure all staff records evidence a completed, current appraisal that are signed to confirm staff have been involved in the process. 60 days
Criterion 3.1.1 During the initial engagement prior to service entry, service providers shall ensure: (a) There is accurate information about the service available in a variety of accessible formats; (b) There are documented entry criteria that are clearly communicated to people, whānau, and, where appropriate, local communities and referral agencies.	PA Moderate	A resident information pack is made available for prospective residents, their family/whānau and referring agencies. Information about the service is available in a variety of formats. Review of documentation and discussion with the clinical manger evidenced that the system in place that clearly communicates the entry criteria to the service requires improvement.	The provider is yet to implement a process that ensures the resident entry criteria is clearly communicated to people, their family/whānau, local communities and referral agencies.	Ensure a process is implemented so that all information pertaining to resident entry is clearly always communicated to people, their family/whānau, local communities and referral agencies. 30 days

Criterion 3.1.5 Service providers demonstrate routine analysis to show entry and decline rates. This must include specific data for entry and decline rates for Māori.	PA Moderate	Discussion with the clinical manager and review of documentation evidenced that the provider does not collate and analyse entry and decline rates as required.	The provider is yet to implement a system that ensures ethnicity data is collated and analysed in relation to entry and decline rates.	Ensure there is a process implemented to collate and analyse ethnicity data. 30 days
Criterion 3.2.3 Fundamental to the development of a care or support plan shall be that: (a) Informed choice is an underpinning principle; (b) A suitably qualified, skilled, and experienced health care or support worker undertakes the development of the care or support plan; (c) Comprehensive assessment includes consideration of people's lived experience; (d) Cultural needs, values, and beliefs are considered; (e) Cultural assessments are completed by culturally competent workers and are 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	PA Moderate	Documentation reviewed and discussion with the clinical manager evidenced that resident care plans maintain a resident centred focus. However, five out of five resident care plans evidenced that the maintenance of these plans requires improvement.	Early warning signs and risks that may adversely affect a person's wellbeing are inconsistently recorded, with insufficient information documented that focuses on prevention or escalation for appropriate intervention.	Ensure all resident care plans document early warning signs, interventions to guide prevention and escalation where appropriate. 60 days

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.				
Criterion 3.2.4 In implementing care or support plans, service providers shall demonstrate: (a) Active involvement with the person receiving services and whānau; (b) That the provision of service is consistent with, and contributes to, meeting the person's assessed needs, goals, and aspirations. Whānau require assessment for support needs as well. This supports whānau ora and pae ora, and builds resilience, self-management, and self-advocacy among the collective; (c) That the person receives services that remove stigma and promote acceptance and inclusion;	PA Moderate	Documentation reviewed and discussion with the clinical manager evidenced that resident care plans maintain a resident centred focus. However, five out of five resident records evidenced that the process in place that documents residents ongoing needs and risk assessments in a timely fashion requires improvement.	Residents changing care needs are inconsistently documented in care plans.	Ensure all resident's care needs are documented in their care plans in a timely fashion. 60 days

(d) That needs and risk assessments are an ongoing process and that any changes are documented.				
Criterion 3.2.5 Planned review of a person's care or support plan shall: (a) Be undertaken at defined intervals in collaboration with the person and whānau, together with wider service providers; (b) Include the use of a range of outcome measurements; (c) Record the degree of achievement against the person's agreed goals and aspiration as well as whānau goals and aspirations; (d) Identify changes to the person's care or support plan, which are agreed collaboratively through the ongoing re-assessment and review process, and ensure changes are implemented; (e) Ensure that, where progress is different from expected, the service provider in collaboration with the person receiving services and whānau responds by initiating changes to the care or support plan.	PA Moderate	Documentation reviewed and discussion with the clinical manager evidenced that care plans maintain a resident focus. However, review of five of five resident care plans confirmed the maintenance of care plans requires improvement.	All five care plans met the required admission timeframes for completion, however three of five had not been reviewed within defined intervals. Three of five did not have a current interRAI completed within required timeframes or when changes had occurred for the resident. Neurological observations were incomplete for one incident form completed following a residents unwitnessed fall. Three of five did not identify changes to the person's care or support plan following an event or change in the resident's health status. Four of five did not evidence that where progress was different from expected, the provider has documented required changes to the care plan.	Ensure all resident care plans are completed, and updated, to maintain required timeframes or when changes are required to meet the residents care needs. 90 days

Criterion 3.3.1 Meaningful activities shall be planned and facilitated to develop and enhance people's strengths, skills, resources, and interests, and shall be responsive to their identity.	PA Moderate	On day two of the audit residents were seen to be enjoying karaoke with a caregiver. However, the implementation of an activity programme that meets residents' needs is yet to be implemented.	The provider is yet to recruit a diversional therapist or an activities coordinator to plan, facilitate and implement a formal activities programme that enhances residents' strengths, skills, and interests.	Ensure a formal activities programme is implemented that enhances the residents' strengths, skills and interests. 60 days
Criterion 3.4.3 Service providers ensure competent health care and support workers manage medication including: receiving, storage, administration, monitoring, safe disposal, or returning to pharmacy.	PA Moderate	Discussion with the clinical manager and review of documentation evidenced that the system in place to record, monitor and maintain medication competency with all staff who administer medications requires improvement. The storage of the medication trolley and medications requires improvement.	i)One staff member continues to administer medication despite not completing their annual competency which is overdue. ii) The medication trolley is stored in the staff room. This is often left unlocked. Medications that cannot fit int the trolley are left on top.	i)Ensure all staff who administer medication retain their medication competency. ii)Always ensure the safe storage of all medications 60 days
Criterion 3.4.6 Service providers shall facilitate safe self-administration of medication where appropriate.	PA Moderate	The medication management policy guides staff in the correct process for any residents who wish to self-administer their medications. However, discussion with the clinical manager evidenced that this was not always followed.	One resident was known to be buying their own pain relief and self-administering this. The medical practitioner was not aware; no regular screening was being completed to ascertain why the resident felt it necessary to take the medication and nor was it documented.	Ensure residents only self-administer their medication following policy and procedure. 60 days
Criterion 3.5.5 An approved food control plan	PA Low	The provider had a food control plan last audit however observation and discussion with	The provider was unable to produce evidence of a current food control	Ensure a current food control plan is in place.

shall be available as required.		the cook did not provide evidence a current food control plan is in place.	plan being in place.	60 days
Criterion 4.1.2 The physical environment, internal and external, shall be safe and accessible, minimise risk of harm, and promote safe mobility and independence.	PA Low	There is evidence of an annual maintenance plan, but it was unable to be confirmed if essential contractors are available 24 hours per day as required. Repairs are required in one resident bathroom. A contractor has been requested to fix the issue however the provider has been informed due to a high workload they are unable to estimate when this can be fixed.	Repairs are required in one resident bathroom, which can only be used by residents who are not cognitively impaired. There is no safety signage, no hazard identification documented.	Ensure where there is a delay in repairs, and identified hazards are noted there is appropriate signage and warning to reduce risk of harm. 60 days
Criterion 5.4.3 Surveillance methods, tools, documentation, analysis, and assignment of responsibilities shall be described and documented using standardised surveillance definitions. Surveillance includes ethnicity data.	PA Moderate	The information collated pertaining to resident infections is comprehensive however the provider does not capture ethnicity data.	Monthly surveillance of infections does not include ethnicity data.	Ensure monthly surveillance of infections includes ethnicity data. 90 days
Criterion 6.1.6 Health care and support workers shall be trained in least restrictive practice, safe practice, the use of restraint, alternative cultural-specific interventions, and de-escalation techniques within a	PA Low	The provider has not utilised any form of restraint for many years. Review of documentation and discussion with the clinical manager evidenced that the staff training provided in relation to restraint requires improvement.	The provider is yet to develop and implement a full training schedule for care staff which includes least restrictive practice, alternative cultural specific interventions, and de-escalation techniques.	Ensure appropriate training is provided for staff in relation to restraint. 60 days

culture of continuous learning.				

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.