Roseridge Healthcare Limited - Roseridge Rest Home Henderson

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity: Roseridge Healthcare Limited

Premises audited: Roseridge Rest Home Henderson

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 8 May 2026 End date: 8 May 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: 17

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

Roseridge Healthcare Limited operates as Roseridge Rest Home (RRH) Henderson and is certified to provide rest home level care for up to 18 residents. There is a new acting facility manager and a new registered nurse/clinical manager.

This surveillance audit process included review of policies and procedures, review of residents' and staff files, observations, and interviews with residents, whānau/family members, the owner, managers, and staff. A new general practitioner has been providing services to residents for five days only and was unavailable for interview.

There were no areas identified as requiring improvement at the last audit. As a result of this audit, improvements are required to:

- The clinical governance framework
- Evaluating quality outcomes
- Review of organisation risks
- Ensuring a staff member is on duty at all times with a current first aid certificate and medication competency
- Evaluation of care
- Ensuring the registered nurse reviews resident progress notes at least weekly

- Assessing that patients are safe to self-administer medications
- Two different aspects related to the infection surveillance programme
- The restraint competency assessment process.

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.

Roseridge Rest Home works collaboratively to support and encourage a Māori worldview of health in service delivery. Māori are provided with equitable and effective services based on Te Tiriti o Waitangi and the principles of mana motuhake.

Pacific peoples are provided with services that recognise their worldviews and are culturally safe.

Residents and their whānau are informed of their rights according to the Code of Health and Disability Services Consumers' Rights (the Code), and these are upheld. Service providers maintain professional boundaries, and there was no evidence of abuse, neglect, discrimination, or other exploitation. The property of residents was respected. Staff interactions observed during the audit demonstrated respectful, culturally safe, and person-centred care delivery.

Policies and the Code provide guidance to staff to ensure informed consent is gained as required. Residents and whānau felt included when making decisions about care and treatment. Residents and whānau interviewed confirmed they were listened to, information was shared in a timely manner, and they were supported to make informed choices.

Complaints are resolved promptly, equitably, and effectively in collaboration with all parties involved.

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.

The director assumes accountability for delivering a high-quality service. This includes ensuring compliance with legislative and contractual requirements, supporting quality and risk management systems, and reducing barriers to improve outcomes for Māori.

The purpose, values, direction, scope and goals for the organisation are defined.

The quality and risk management systems are focused on improving service delivery and care using a risk-based approach and the collection of data.

The National Adverse Events Policy is followed, with corrective actions supporting systems learnings. Statutory and regulatory reporting obligations were met in relation to the new acting facility manager and registered nurse/clinical manager.

Staff have the skills, attitudes, qualifications and experience to meet the needs of residents. A systematic approach to identify and deliver ongoing learning and competencies supports safe, equitable service delivery.

Professional qualifications are validated prior to employment. Staff felt well supported through the orientation and induction programme, with regular performance reviews implemented.

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 service works in partnership with residents and their whānau to assess, plan, and deliver care. Care plans were individualised and based on comprehensive risk-based assessments. Assessment processes considered residents' clinical, cultural, and psychosocial needs. Files reviewed demonstrated multidisciplinary involvement and communication processes that supported continuity of care and resident wellbeing.

Medicines are safely stored. There is a staff medication competency programme. Medication management systems observed during the audit supported safe prescribing, dispensing, storage, and administration of medicines in accordance with current requirements and organisational policy.

The food service meets the nutritional and cultural needs of the residents. Food is safely managed and is supported by an approved food control plan. Residents' dietary preferences, special diets, and cultural needs were accommodated. Menu review by a qualified dietitian supported the provision of appropriate nutrition and hydration.

Residents are referred or transferred to other health services as required. Transfer and referral processes included appropriate communication and documentation to support continuity of care and ongoing service delivery.

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, plant and equipment meet the needs of residents and are culturally inclusive. A current building warrant of fitness and planned maintenance programme are in place. Clinical and electrical equipment is tested as required.

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.

A documented infection prevention and control programme has been developed with appropriate infection prevention expertise, approved through organisational governance, and is linked to the quality improvement programme at Roseridge Rest Home.

Staff demonstrated knowledge of infection prevention and control principles and practice, supported through orientation, ongoing education, and regular training. Staff interviewed were knowledgeable regarding standard precautions, hand hygiene practices, and outbreak management processes.

Infection prevention and control resources, personal protective equipment, and relevant guidance documentation were available to support safe practice and service delivery.

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 uses environmental restraint. This is supported by the governing body and policies and procedures. There were no residents using other restraints at the time of audit.

Staff have been provided with training, including de-escalation techniques and alternative interventions.

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	11	0	2	5	0	0
Criteria	0	39	0	3	7	0	0

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

Attainment against the Ngā paerewa Health and disability services standard

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

For more information on the standard, please click here.

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

Subsection with desired outcome	Attainment Rating	Audit Evidence
Subsection 1.1: Pae ora healthy futures Te Tiriti: Māori flourish and thrive in an environment that enables good health and wellbeing. As service providers: We work collaboratively to embrace, support, and encourage a Māori worldview of health and provide high-quality, equitable, and effective services for Māori framed by Te Tiriti o Waitangi.	FA	Roseridge Rest Home has developed policies, procedures and processes to embed and enact Te Tiriti o Waitangi in all aspects of its work. Mana motuhake is respected. Partnerships have been established with Māori organisations to support service integration, planning, equity approaches, and support for Māori. These organisations are identified in discussions with individual residents and their whānau. There were Māori residents at the time of audit, and those interviewed felt culturally safe.
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	Roseridge Rest Home provides services that are underpinned by Pacific worldviews. Pacific residents interviewed felt their worldview, and cultural and spiritual beliefs, were embraced. Community Pacific groups visit on site as part of the activities programme. There were Pacific residents and staff. Staff and whānau interviewed detailed how individual resident needs were being met.

Subsection 1.3: My rights during service delivery The People: My rights have meaningful effect through the actions and behaviours of others. Te Tiriti:Service providers recognise Māori mana motuhake (self-determination). As service providers: We provide services and support to people in a way that upholds their rights and complies with legal requirements.	FA	Staff interviewed demonstrated an understanding of the requirements of the Code of Health and Disability Services Consumers' Rights and were observed supporting residents in ways that respected their preferences, dignity, independence, and cultural values. Whānau and legal representatives interviewed reported being informed about the Code and the Nationwide Health and Disability Advocacy Service. Evidence was sighted of training provided to staff in relation to Māori mana motuhake, advocacy, cultural safety, and the Code of Rights. Opportunities to discuss and clarify residents' rights were provided during admission and through ongoing communication processes. Residents and whānau interviewed at Roseridge Rest Home confirmed they were provided with clear information about their rights and felt supported in having their choices, wishes, privacy, and independence respected.
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	Residents at Roseridge Rest Home receive services in an environment free from discrimination, coercion, harassment, exploitation, abuse, and neglect. This is supported by relevant policies and regular staff education. During the audit, no concerns relating to these matters were identified through interviews with staff, residents, whānau or legal representatives, and review of documentation. Residents and legal representatives generally manage residents' personal finances. Where residents choose to have money securely stored within the facility, this is managed by the acting facility manager through established processes, including the use of electronic systems to record and monitor transactions and withdrawals as required. Residents and legal representatives interviewed confirmed satisfaction with these arrangements. Staff interviewed demonstrated an understanding of professional boundaries and the requirements of the Code. Evidence sighted confirmed relevant training had been provided. Residents and whānau interviewed confirmed satisfaction with the service, noting staff were respectful, responsive, and consistent in their approach.

		Feedback reflected respectful interactions and safe care delivery.
Subsection 1.7: I am informed and able to make choices The people: I know I will be asked for my views. My choices will be respected when making decisions about my wellbeing. If my choices cannot be upheld, I will be provided with information that supports me to understand why. Te Tiriti: High-quality services are provided that are easy to access and navigate. Providers give clear and relevant messages so that individuals and whānau can effectively manage their own health, keep well, and live well. As service providers: We provide people using our services or their legal representatives with the information necessary to make informed decisions in accordance with their rights and their ability to exercise independence, choice, and control.	FA	Residents, whānau, and Enduring Powers of Attorney (EPOAs) are provided with information to support informed decision-making in accordance with the Code. Residents and whānau interviewed confirmed they are supported to participate in decision-making processes and, with resident consent, whānau are involved as appropriate. Residents and legal representatives interviewed spoke positively regarding communication processes and the service's promotion of residents' rights and involvement in care. Advance care planning and EPOA documentation were evident in records reviewed. Admission agreements were appropriately signed by the resident or their representative. Informed consent documentation sighted included general consent forms, resuscitation decisions, environmental restraint consent forms where applicable, and other relevant consents, which residents and EPOAs interviewed confirmed had been discussed and understood. Staff interviewed, including care staff and support staff, demonstrated knowledge of informed consent principles and organisational processes relevant to their roles. Evidence of education and training was sighted within staff training records. Staff demonstrated an understanding of consent, residents' rights, privacy, and cultural safety, supported by organisational policies and training.
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	FA	A fair, transparent, and equitable system is in place to receive and resolve complaints that leads to improvements. The process meets the requirements of the Code. Residents and whānau interviewed understood their right to make a complaint and knew how to do so. Information on the complaints process is displayed for residents. There have been eight complaints received since 26 February 2025, with one resident making four of these complaints. Complaints were acknowledged in a timely manner. Documentation sighted showed that complainants had been informed of findings following

improvement.		investigation. The service assures that the process works equitably for Māori. The owner advised that this includes obtaining an interpreter if required and offering to meet with the resident and whānau in person, rather than communicating in writing. There has been one recent complaint received from external sources. The complaint from a resident was via the independent advocacy service. The complaint was responded to in a timely manner, with the management team meeting with the resident/complainant, their activated EPOA, and the independent advocate to discuss the concerns raised and determine next steps. Associated documentation was sighted.
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	The owner is also the sole company director (director), purchasing the care home in 2019. The director is a registered nurse and maintains a current annual practising certificate. The owner assumes overall accountability for delivering a high-quality service to users of the services and their whānau. Compliance with legislative, contractual and regulatory requirements is overseen by the director, with external advice sought as required. An external contractor assists with updating policies and procedures when legislation changes. There is a new management team, both of whom are new to management responsibilities within the aged residential care (ARRC) sector. The acting facility manager (AFM) is responsible for ensuring the day-to-day care needs of residents are met. A Section 31 notification was made to HealthCERT regarding the appointment of the new AFM and the new registered nurse/clinical manager. This links with subsection 2.2. The purpose, values, direction, scope, and goals are defined. The director monitors and reviews organisational performance via regular meetings and conversations with the acting facility manager (AFM) and the registered nurse/clinical manager (RN/CM), and by attending monthly staff meetings. The director is on site in the care home several times per week. A focus on identifying barriers to access, improving outcomes, and achieving equity for Māori was evident in the plans and monitoring documentation reviewed, and through interview with the director. This

		includes effective communication with community agencies and providing bedrooms that do not incur premium room charges. A commitment to the quality and risk management system was evident. The owner made changes to the staff meeting minute template earlier in April 2026 after identifying gaps in information being provided/discussed, in order to help improve the flow of quality and risk-related information. This links with the area for improvement raised in criteria 2.2.3 and 2.2.4. The clinical governance structure is also an area requiring improvement. The service holds agreements with Health New Zealand – Te Whatu Ora for the provision of rest home and long-term support – chronic health conditions (LTS-CHC). The care home was fully occupied, with 17 residents present at the time of audit and one other resident currently an inpatient in acute care services. Of those 17 residents physically present on the day of audit, 11 were receiving rest home-level care and two were receiving LTS-CHC at rest home level under ARRC agreements. Three other residents were privately funding long-term rest home-level care. There was one resident under the age of 65 years who is funded by the Ministry of Social Development – Disability Support Services.
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	The organisation has a planned quality and risk system that reflects the principles of quality improvement. This includes management of incidents and complaints, internal audit activities, a regular resident satisfaction survey, monitoring of outcomes, policies and procedures, clinical incidents including infections, and regular staff training. A resident satisfaction survey is in the process of being undertaken. The feedback from the five resident responses received to date was overall positive. The AFM is working to increase the survey response rate. Resident meetings occur most months. The minutes were sighted and reflected discussion on day-to-day activities and, at times, suggestions for changes to food services. No significant concerns were raised in the five sampled sets of minutes from September 2025 to February 2026, with the exception of concerns regarding smoke alarms being falsely triggered, which were raised at the February 2026 meeting. This issue was reported to have improved since that meeting. The director advised that ongoing discussions are continuing in relation to this matter.

		Relevant corrective actions are developed and implemented to address any shortfalls. Progress against quality outcomes is evaluated. Policies reviewed covered all necessary aspects of the service and contractual requirements and were current. These are developed by an external consultant and updated by the director to reflect Roseridge Rest Home. They are available electronically, and a paper-based manual of documents is also available for staff to access easily. The director described the processes for the identification, documentation, monitoring, review and reporting of risks. However, these processes are not consistently implemented, and this is an area requiring improvement. Staff document adverse and near-miss events in line with the National Adverse Events Policy. A sample of incidents forms reviewed showed these were completed, incidents were investigated, action plans developed, and actions followed up in a timely manner. The director understood the essential notification reporting requirements and has made notifications in relation to the changes in facility manager and registered nurse/clinical manager. This links with subsection 2.1. A Section 31 notification was not made in relation to the recent MediMap outage, as the service moved to paper-based records with the assistance of the local pharmacy, with minimal interruption. The owner stated that residents were not at risk. A Section 31 notification in relation to this event was retrospectively made on the day of audit. The is not raised as an area for improvement as it did not reflect a systemic issue. There have been no police investigations, coroner's inquests, issues-based audits, or any other essential notifications since the last 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. 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.	PA Low	There is a documented process for determining staffing levels and skill mixes to provide culturally and clinically safe care, 24 hours a day, seven days a week (24/7). Records were not available to demonstrate that one health care assistant (HCA) rostered on site alone had a current first audit certificate and medication competency. While the roster was changed during audit, this is an area requiring improvement to ensure this remains a consideration during future rostering. On occasions, students working towards achieving an industry-approved qualification in aged care are on site to undertake practical work experience. There were no students

As service providers: We ensure our day-to-day operation is managed to deliver effective person-centred and whānau-centred services.		currently providing services at Roseridge Rest Home. The employment process, which includes a job description defining the skills, qualifications and attributes for each role, ensures services are delivered to meet the needs of residents. Continuing education is planned on a biannual basis, including mandatory training requirements. Related competencies are assessed and support equitable service delivery. Records reviewed demonstrated completion of the required training and competency assessments. However, staff were not completing the questions in the restraint competency correctly. This is raised as an area for improvement in criterion 6.1.6. Staff confirmed that training is provided at the monthly staff meetings and includes external speakers. Care staff have either completed or commenced a New Zealand Qualifications Authority education programme to meet the requirements of the provider's agreement with the Health New Zealand – Te Whatu Ora. One staff member has a Level 3 qualification, four staff have a Level 4 qualification, and two staff (including the AFM) have a Level 7 qualification.
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	Human resources management policies and processes are based on good employment practice and relevant legislation. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented, including evidence of qualifications and registration (where applicable). Current annual practising certificates (APCs) were sighted for employed and contracted registered health professionals. The rest home pharmacy is awaiting renewal of its pharmacy licence. Email communication from the applicable licensing agency confirmed that all applicable information to renew the licence had been provided, and noted that there was a backlog in processing applications. In the interim, the existing licence is stated 'to be valid until further notice'. The email documentation to this effect was sighted. Staff reported that the induction and orientation programme prepared them well for the role, and evidence of this was seen in files reviewed. Opportunities to discuss and review performance occur at least annually following appointment, as confirmed in records reviewed.

Subsection 3.2: My pathway to wellbeing The people: I work together with my service providers so they know what matters to me, and we can decide what best supports my wellbeing. Te Tiriti: Service providers work in partnership with Māori and whānau, and support their aspirations, mana motuhake, and whānau rangatiratanga. As service providers: We work in partnership with people and whānau to support wellbeing.	PA Moderate	The multidisciplinary team at Roseridge Rest Home works in partnership with residents and whānau to support wellbeing. Care plans are developed by suitably qualified staff following assessment processes that consider residents' lived experience, cultural needs, values and beliefs, and wider service integration where required. Initial assessments were completed within required timeframes. Risks and early warning signs were identified, documented, and managed, with a focus on prevention, monitoring, and escalation where required. Assessment findings and diagnoses were reflected in care planning and interventions, including support for residents with chronic health conditions, mental health support needs, mobility support needs, long-term disability support needs, and residents aged under 65 years. General practitioner, mental health services, and allied health input were evidenced where indicated. Documentation evidenced resident involvement in care planning and decision-making processes, including choice, independence, participation in activities of choice, and community engagement. Staff interviewed demonstrated awareness of residents' support requirements, interventions, preferences, and community participation goals. Documentation reviewed, observations, and staff interviews evidenced care delivery aligned with assessed needs and service requirements. Residents and their whānau are supported to participate in decision-making in accordance with the Code. Information relating to informed consent, advance directives, and service expectations is provided during admission. Records reviewed confirmed residents, and where applicable, EPOA representatives were involved in care planning and review processes. Staff interviewed demonstrated an understanding of assessment, care planning, and informed consent processes in line with organisational policies and practice expectations. Staff support Māori and whānau to identify their own pae ora outcomes in care planning processes. This was verified through review of residents' records and interviews with staff, residents, and whānau. Management of residents' clinical needs was supported through assessment, monitoring, and review processes. Where changes in residents' needs were identified, care planning processes supported review

		and response in collaboration with residents and/or whānau. Residents and whānau interviewed confirmed active involvement in care planning and decision-making. There is an opportunity for improvement in relation to consistency of long-term care plan evaluations, environmental restraint documentation within long-term care plans, neurological monitoring following unwitnessed falls, and completion of registered nurse progress notes in accordance with organisational policy.
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	The medication management policy at Roseridge Rest Home was current and aligned with the Medicines Care Guide for Residential Aged Care and current best practice. A safe system for medicine management using an electronic medication management system was observed on the day of audit. Health care assistants administering medications demonstrated practice consistent with documented procedures, and medication competencies were current, with the exception of one applicable staff member. Refer to the area requiring improvement raised in criterion 2.3.1. Medication reconciliation occurred on receipt of pharmacy supplies and all medications sighted were within current use-by dates. Medicines were stored safely. There were no controlled drugs within the facility at the time of audit; however, a secure controlled drug safe and controlled drug register were available should controlled drugs require storage within the service. Health care assistants interviewed demonstrated knowledge regarding controlled drug storage and associated processes. Medication storage temperatures were monitored and maintained within recommended ranges. Prescribing practices met requirements, including documentation of allergies and sensitivities, three-monthly prescriber review, and appropriate management of adverse events. PRN medication administration included documentation of indication and effect. There were no standing orders in use within the facility, as confirmed by the acting facility manager. Self-administration of medication was facilitated within the service. However, the self-administration medication assessments and associated GP and registered nurse review to ensure appropriateness and resident safety had not been undertaken in accordance with organisational policy.

Subsection 3.5: Nutrition to support wellbeing The people: Service providers meet my nutritional needs and consider my food preferences. Te Tiriti: Menu development respects and supports cultural beliefs, values, and protocols around food and access to traditional foods. As service providers: We ensure people's nutrition and hydration needs are met to promote and maintain their health and wellbeing.	FA	The menu at Roseridge Rest Home was developed in line with recognised nutritional guidelines for aged care services and reflected residents' individual food preferences and cultural needs. Food services were provided on site by the facility kitchen team. Evidence of resident satisfaction with meals was confirmed through resident interviews and feedback obtained during the audit. Residents interviewed provided positive feedback regarding meal quality, variety, and availability of food and fluids. Snacks and fluids were available throughout the day to meet resident needs and preferences. Residents interviewed confirmed that food and fluids were available on request. The menu followed a seasonal cycle and had been reviewed by a registered dietitian. The menu incorporated residents' cultural preferences and dietary requirements, including texture-modified and special diets. Current resident dietary profiles were maintained to support meals being prepared in accordance with individual requirements. The service operated under an approved food control plan valid from 13 May 2025 until 13 May 2026. Evidence was sighted of the acting facility manager communicating with the local council regarding scheduling of the 2026 food control plan verification audit.
Subsection 3.6: Transition, transfer, and discharge The people: I work together with my service provider so they know what matters to me, and we can decide what best supports my wellbeing when I leave the service. Te Tiriti: Service providers advocate for Māori to ensure they and whānau receive the necessary support during their transition, transfer, and discharge. As service providers: We ensure the people using our service experience consistency and continuity when leaving our services. We work alongside each person and whānau to provide and coordinate a supported transition of care or	FA	Transfer or discharge from Roseridge Rest Home was planned and managed safely, with coordination between services and collaboration with residents and their whānau or EPOA. Risks and current support needs were identified and managed. Residents and whānau interviewed confirmed they were informed and involved in transfer and discharge processes. Processes were in place for both acute and planned hospital transfers. The service utilised transfer documentation, including yellow envelopes, with required clinical information accompanying residents during transfer. Staff used structured communication processes when liaising with medical practitioners and hospital services, as confirmed through staff interviews and documentation reviewed. Post-discharge planning and follow-up were

support.		documented within resident records, with referral and specialist documentation sighted in files reviewed. Evidence was sighted of a recent hospital transfer following a resident fall, where the health care assistant appropriately escalated concerns to the registered nurse. Documentation reviewed evidenced clear incident documentation, handover information provided to ambulance services and hospital staff, and follow-up registered nurse documentation and GP notes following transfer. There was evidence of coordinated admission and transition processes. There was evidence of a clear and structured pathway for escalation and transfer. Staff interviewed demonstrated knowledge of transfer processes and requirements, supporting safe and coordinated transitions 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	Building, plant and equipment are fit for purpose, inclusive of peoples' cultures, and comply with relevant legislation. This includes a current building warrant of fitness (expiry date: 30 September 2026), and electrical and biomedical testing. Equipment sighted had labels of current testing, and a master report detailing contractor checks was sighted. Use of safety chains on one of the external fire exit doors has been included in the area for improvement raised in criterion 2.2.4. Residents and whānau were happy with the environment, including heating and ventilation, natural light, privacy, and maintenance.
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	FA	The infection prevention and control coordinator (IPCC), the clinical manager, is responsible for overseeing and implementing the infection prevention and control programme at Roseridge Rest Home. The infection prevention and control programme is linked to the quality improvement programme and is reviewed annually. The annual review and programme were approved by the governing body, as evidenced in governance documentation and review of programme records.

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.		An infection prevention and control committee is established and meets regularly to review infection events, analyse trends, monitor surveillance data, and inform prevention strategies. Committee records evidenced oversight of infection prevention activities, review of infection data, corrective actions, and reporting through governance structures. The IPCC has oversight of infection prevention and control processes and reports through organisational and governance channels to support accountability. Staff interviewed demonstrated familiarity with infection prevention and control policies and procedures, including outbreak management processes, supported through orientation and ongoing education. Staff training records evidenced ongoing infection prevention and control education, including outbreak management training. Staff interviews confirmed understanding of infection prevention practices and implementation requirements. Residents and their whānau received information relating to infection prevention and control in a manner appropriate to their needs. Resident and whānau interviews, staff interviews, and education records evidenced communication and ongoing education relating to infection prevention and control.
Subsection 5.4: Surveillance of health care-associated infection (HAI) The people: My health and progress are monitored as part of the surveillance programme. Te Tiriti: Surveillance is culturally safe and monitored by ethnicity. As service providers: We carry out surveillance of HAIs and multi-drug-resistant organisms in accordance with national and regional surveillance programmes, agreed objectives, priorities, and methods specified in the infection prevention programme, and with an equity focus.	PA Moderate	Surveillance of health care associated infections at Roseridge Rest Home was aligned with the size and complexity of the service and reflected risks and priorities identified within the infection prevention and control programme. The clinical manager, supported by the acting facility manager, was responsible for oversight of infection prevention and control processes, with infection-related information and reporting shared with the director through organisational reporting pathways. There had been no outbreaks within the facility since the previous audit. Staff interviewed demonstrated knowledge of outbreak management processes, including isolation procedures, use of personal protective equipment, communication processes, and escalation requirements. Staff interviews and education records evidenced that infection prevention and control processes were discussed through staff meetings, handovers, and ongoing education. Evidence was sighted of the acting facility manager liaising with other aged

		care providers within Auckland regarding infection rate benchmarking and communication with Health New Zealand – Te Whatu Ora regarding benchmarking processes and infection prevention monitoring. This is yet to be implemented. The infection prevention and control programme was aligned with organisational planning and risk management processes to support implementation of infection prevention strategies. There are areas for improvement in relation to completion of infection surveillance monitoring and documentation of surveillance analysis, in accordance with organisational policy and funder contract requirements. This links with information in subsections 2.1 and 2.2 and the areas for improvement raised in criteria 2.1.11 and 2.2.3.
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	The director stated that the service does not allow the use of restraint, with the exception of environmental restraint, as the external gate has a keypad code. This is discussed with residents and whānau prior to entering the service, and written consent is obtained. Written consent forms were present in all sampled resident files, signed either by competent residents or their activated enduring power of attorney. Residents are informed of the exit code; however, not all residents can remember the code. Staff will open the gate for residents who want to go out, and in the event where there are safety concerns, a staff member or a family member will accompany the resident if staffing permits. The AFM and director advised that the locked gate is in place because the rest home is located on the intersection of two busy roads, and that it has been in use 'for a long time' as part of ensuring resident safety. Policy notes that the resident's individualised care plan should include an assessment of the impact of this locked gate and the strategies to mitigate any risk. This is not occurring and is included in the area for improvement raised in criterion 3.2.4. Environmental restraint is included in the organisation's restraint policy. The impact of environmental restraint is not being discussed at the monthly staff meeting. This links with the areas requiring improvement raised in criteria 2.1.11 and 2.2.3. At the time of audit, there was environmental restraint in use. No other types of restraint were in use.

		Staff reported that they have been trained in the least restrictive practice, safe restraint practice, alternative cultural-specific interventions, and de-escalation techniques. However, the answers in the staff annual restraint competency demonstrated that staff did not fully understand organisation requirements.

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 2.1.11 There shall be a clinical governance structure in place that is appropriate to the size and complexity of the service provision.	PA Moderate	There is a new management team. A registered nurse (RN) was employed in early December 2025 and works on site two days a week as the RN and clinical manager (RN/CM), and is available on call. The RN/CM is new to the aged residential care (ARRC) sector. An orientation programme was provided prior to the previous RN/CM finishing in the role in February 2026. The previous RN/CM remains available to provide assistance if required and to cover the RN roster on a casual basis. The residential care officer,	A clinical governance structure appropriate to the size and complexity of the services being provided is not being currently implemented.	Implement a clinical governance structure that is appropriate to the size and complexity of the services being provided. 90 days

		who has worked at Roseridge Rest Home since 2018, was appointed as the acting facility manager in February 2026 until the end of June 2026, when the arrangement will be reviewed. This is the first management position held by the new acting facility manager (AFM), who is responsible for ensuring the day-to-day care needs of the residents are being met. The director is providing advice and support. With changes in management personnel, both of whom are new to management responsibilities within an ARRC service and are learning their roles and responsibilities, a number of gaps impacting clinical governance were identified. These have been raised as areas for improvement under various criteria in this audit report. The gaps identified indicate that the overall clinical governance framework is no longer fully effective and requires improvement.		

Criterion 2.2.3 Service providers shall evaluate progress against quality outcomes.	PA Moderate	Monthly staff meetings are used to advise staff of reported events, incidents, and complaints, including themes and trends, changes to policies and procedures, and rest home practices. The meeting template also includes sections for discussion of restraint and infection surveillance data, and any actions required. Gaps were identified in the reporting and analysis of infection data. This links with the areas for improvement raised under criteria 5.4.3 and 5.4.4. While staff noted that discussions occurred, the minutes of three out of four staff meetings sighted (January to March 2026) did not explicitly include much of the information that was reported to have been discussed. The director has started to change this by implementing a more specific template that includes a section for all relevant issues to be recorded. The April 2026 meeting minutes were more comprehensive and included two weeks of April 2026 data due to the timing	There is insufficient evaluation of progress towards achieving quality outcomes. Gaps include appropriate analysis of restraint, reported events/incidents and infections, and communication with staff on the results of internal audits undertaken. Ethnicity data is not being included and analysed where applicable.	Ensure a consistent process is in place to evaluate progress against quality outcomes, including restraint, incidents/reportable events, infections, and internal audit outcomes. Include ethnicity data in analysis where required to meet these standards. 90 days

		of the meeting. However, they did not include information related to the impact of environmental restraint, internal audit results, sufficient incident and reportable event information and analysis, or infection analysis and surveillance data, including trends. Ethnicity information had not been included where this was required.		
Criterion 2.2.4 Service providers shall identify external and internal risks and opportunities, including potential inequities, and develop a plan to respond to them.	PA Moderate	The owner described the processes for the identification, documentation, monitoring, review and reporting of risks, including health and safety risks, and development of mitigation strategies. The internal audit programme is part of the processes being used to evaluate risk and the effectiveness of mitigation strategies. However, there is no clear linkage with audit outcomes and the risk register. The risk register was not dated as reviewed since the last audit. During the audit, it was observed that a safety chain was at the top of the external door in one of the wings. This was reported to have	The internal risk monitoring framework includes the use of internal audits to help evaluate risk effectiveness of mitigation strategies. While audits are occurring, there is no linkage between the audit results and the risk monitoring framework. The risk register does not include all applicable/current risks. The risk register has not been reviewed since the last audit.	Ensure the risk register is reviewed and updated on a scheduled basis and whenever there are changes in organisational risk, including risks related to information technology platforms and external exit security and monitoring. Ensure the effectiveness of risk mitigation strategies is monitored and linked as appropriate with the internal audit and quality programme. 90 days

		been installed when a resident was wandering. However, this door is one of the external fire exit doors. A representative from the company undertaking the monthly fire safety testing as part of the Building Warrant of Fitness was present on the afternoon of the audit undertaking checks of fire safety systems within the rest home and verified that this chain should not be present. The chain was removed by the contractor at the request of the director. The director advised that another option will be explored to alert staff if an external door is opened, particularly after hours. Neither issue was included in the risk register. There are four different electronic systems in use that contain resident data and information, including interRAI, an electronic medication management system, one used for resident progress notes and incident reporting, and another used for staff rostering and general communication with staff regarding updates and issues. A separate platform		

		is used for policies and the storage of other files. During discussions, it was unclear what backup and information security framework is in place for these systems to ensure access to and protection of stored information.		
Criterion 2.3.1 Service providers shall ensure there are sufficient health care and support workers on duty at all times to provide culturally and clinically safe services.	PA Low	There is a documented process for determining staffing levels and skill mixes to provide culturally and clinically safe care, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. However, at the audit, records were not available to demonstrate that one HCA who works on site on their own has a current first aid certificate and medication competency. The AFM and director were sure this training had been completed, but were unable to locate the records. The AFM and director made immediate amendments to the roster to cover the applicable shifts until the records were available. There is a minimum of one staff member on duty, and the	There was a staff member rostered working alone on site who did not have evidence of having a current first aid certificate and medication competency.	Ensure a staff member is always rostered on duty with a current first aid certificate and medication competency. 90 days

		clinical manager/RN, director, and AFM are on call. A multidisciplinary team (MDT) approach ensures all aspects of service delivery are met. Those providing care reported there were adequate staff to complete the work allocated to them. Residents and whānau interviewed supported this. The RN/CNM is on site two split days Monday and Saturday each week. The AFM is on site Monday to Friday 7.30 am to 4 pm. On the weekend, an additional HCA works 7 am to 11 am. Two staff share the cooking duties and are on site between 9 am and 5.30 pm. A new general practitioner (GP) is providing services. The GP is located at a nearby practice, which staff advised makes access easier for residents. Staff take residents to the GP practice for routine and more acute reviews. Communication between staff and the GP about changing resident conditions was sighted. Despite attempts, the GP was unable to be interviewed during		

		audit. Pharmacy services are provided by a designated pharmacy. The HCA staff undertake cleaning and laundry duties shared over the 24-hour period.		
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	PA Moderate	Residents and whānau interviewed confirmed involvement in care planning and review. Records reviewed evidenced that care plans reflected assessed needs, risks, and interventions. However, five out of five resident files reviewed did not evidence completed long-term care plan evaluations. Environmental restraint documentation, including reason for use, potential impact, interventions, and the review process, was not documented within long-term care plans as required by organisational policy. Neurological monitoring following an unwitnessed fall was also not consistently completed in accordance with organisational policy.	Not all files evidenced completed long-term care plan evaluations, environmental restraint documentation within long-term care plans, and neurological monitoring following an unwitnessed fall in accordance with organisational policy requirements.	Ensure long-term care plan evaluations are completed and environmental restraint documentation within long-term care plans includes reason for use, potential impact, interventions, and review. Ensure neurological monitoring following unwitnessed falls is completed in accordance with organisational policy requirements. 90 days

inclusion; (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	PA Moderate	Residents and whānau interviewed confirmed they were informed of changes in residents' conditions and involved in care discussions. Documentation reviewed evidenced ongoing monitoring processes, GP involvement, and multidisciplinary communication to support continuity of care. However, registered nurse progress notes were not consistently completed weekly, or following changes in condition or GP reviews, as required by organisational policy.	Not all files evidenced completion of registered nurse progress notes weekly, or following changes in condition or GP reviews, in accordance with organisational policy requirements.	Ensure registered nurse progress notes are completed weekly and following changes in condition or GP reviews, in accordance with organisational policy requirements. 90 days

expected, the service provider in collaboration with the person receiving services and whānau responds by initiating changes to the care or support plan.				
Criterion 3.4.6 Service providers shall facilitate safe self-administration of medication where appropriate.	PA Moderate	Self-administration of medication was facilitated within the service. Health care assistants interviewed demonstrated awareness of self-administration procedures and associated monitoring and storage requirements in accordance with organisational policy. Records reviewed identified two residents self-administering medications within the facility. However, self-administration medication assessments and associated GP and registered nurse review requirements were not completed in accordance with organisational policy.	Two residents self-administering medications did not have completed self-administration medication assessments and associated GP and registered nurse reviews in accordance with organisational policy requirements.	Ensure residents self-administering medications have completed self-administration medication assessments and associated GP and registered nurse reviews in accordance with organisational policy requirements. 90 days
Criterion 5.4.3 Surveillance methods, tools, documentation, analysis, and assignment of responsibilities shall be	PA Low	The RN/clinical manager, supported by the acting facility manager, had oversight of infection prevention and control	Records were not available to demonstrate that infection surveillance monitoring had been completed for the last four months in accordance with organisational policy	Ensure infection surveillance monitoring is completed consistently, that analysis and responsibilities for follow-up are clear, that ethnicity data is evaluated in accordance with

described and documented using standardised surveillance definitions. Surveillance includes ethnicity data.		processes. Staff interviewed demonstrated knowledge of infection prevention and control and outbreak management processes. However, records were not available to demonstrate that infection surveillance monitoring had been completed for the last four months. Staff interviewed were sure this had been done but were unsure where these records were located during the audit. Ethnicity data was not included in records sighted.	requirements. Ethnicity data was not included in records sighted.	organisational policy and funder contract requirements, and that records are accessible. 180 days
Criterion 5.4.4 Results of surveillance and recommendations to improve performance where necessary shall be identified, documented, and reported back to the governance body and shared with relevant people in a timely manner.	PA Moderate	Staff interviewed demonstrated awareness of infection prevention and control responsibilities and escalation processes. Infection prevention and control information was communicated through some staff meetings and during shift handovers. For the period January 2025 to date, the one-page summary of infections was inconsistently completed. This was completed in only five months of 2025 and nil to date in 2026. There was inconsistent evaluation/analysis, and no	There is inconsistent analysis of surveillance data, and no recommendations/suggestions for improvement have been made in relation to the infection prevention programme based on surveillance data since January 2025.	Ensure there is consistent analysis of the infection data and recommendations/improvements identified, implemented and reported in accordance with organisational policy requirements and funder contract requirements. 90 days

		recommendations for suggested changes in practice or staff training that may help reduce/improve infection rates have been documented. Instead, the analysis notes 'no change'.		
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 culture of continuous learning.	PA Low	Staff are required to complete a restraint competency as part of orientation and then annually as part of the staff training and competency programme. Current restraint competencies were completed in sampled staff files. However, there was a variety of answers as to whether restraint could be used on site and, if so, the type of approved restraints. There was no evidence of follow-up with staff who noted incorrect information. For example, answers included wrist restraint, chemical restraint, bedrails and lap belts as being approved restraints. The AFM and director advised that the service does not allow any of these types of restraints and does not have wrist restraints, bedrails or lap belts available on site. Staff confirmed that	Staff complete an annual restraint competency. However, the information recorded by staff in relation to approved restraint does not align with the organisation's policy.	Ensure that staff understand the organisation's restraint policy, and that the associated competency forms are reviewed and followed up in the event staff do not answer the questions appropriately. 180 days

		medication is only administered in accordance with individual residents' medication prescriptions and specified indications, and that no restraint other than environmental restraint was being used.		

Specific results for criterion where a continuous improvement has been recorded

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

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

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

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End of the report.