The Ultimate Care Group Limited - Ultimate Care Cambridge Oakdale

Introduction

This report records the results of a Certification Audit of a provider of aged residential care services against the Ngā Paerewa Health and Disability Services Standard (NZS8134:2021).

The audit has been conducted by Central Region's Technical Advisory Services Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to 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 Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	The Ultimate Care Group Limited
Premises audited:	Ultimate Care Cambridge Oakdale
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 8 August 2023 End date: 9 August 2023

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: 46

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

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

Key to the indicators

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

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

General overview of the audit

Ultimate Care Cambridge Oakdale is part of the Ultimate Care Group Limited. It is certified to provide care for up to 47 residents requiring rest home, hospital, or dementia level services. Since the previous audit a new clinical services manager and an acting facility manager had been appointed.

This certification audit was conducted against Ngā Paerewa Health and disability services standard NZS 8134:2021 and the service contracts with Te Whatu Ora Waikato. The auditors also followed up on areas requested by HealthCERT.

The audit process included review of policies and procedures, and resident and staff files, observations and interviews with staff, residents, family/whānau, and a nurse practitioner.

Areas identified as requiring improvement relate to consent, quality improvement, staffing levels, human resource management, entry to service, medication management, infection surveillance, and cleaning.

Ō tatou motika | Our rights

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

There were policies and procedures to support staff in delivering culturally safe care. Staff received training in Te Tiriti o Waitangi and cultural safety. A Pacific plan was in place to ensure cultural safety for Pacific peoples and that their worldviews, cultural and spiritual beliefs were embraced.

Resident rights were respected and upheld in line with the Health and Disability Commission Code of Health and Disability Services Consumers' Rights. Residents received services in a manner that was responsive to and respected their individuality and upheld their right to dignity, privacy and independence.

Policies were implemented to support resident's rights, ensure open communication, and protect them from abuse and neglect. There was a policy and process to manage complaints.

Hunga mahi me te hanganga | Workforce and structure

Includes 5 subsections that support an outcome where people receive quality services through effective governance and a supported workforce.		Some subsections applicable to this service are partially attained and of medium or high risk and/or unattained and of low risk.

Ultimate Care Group is the governing body responsible for services provided at this facility. The facility was managed by a suitably experienced acting facility manager who was supported by a clinical service manager and a team of registered nurses. A regional manager also provided support to the facility manager.

There was a current documented quality and risk management system, that provided a framework for continuous quality improvement. It included a schedule of internal audits and incident management and reporting.

There were documented human resource policies and procedures that were in line with good employment practice and met the requirements of legislation. Processes for staff orientation and training were implemented.

There was a current and implemented policy to ensure that resident's health records were an accurate reflection of the interaction between the health care provider and the resident. Resident documentation was integrated, and systems were in place to ensure the security of all information.

Ngā huarahi ki te oranga | Pathways to wellbeing

Includes 8 subsections that support an outcome where people participate in the development of their pathway to wellbeing, and receive timely assessment, followed by services that are planned, coordinated, and delivered in a manner that is tailored to their needs.		Some subsections applicable to this service are partially attained and of low risk.

Ultimate Care Oakdale provided a model of care that ensured holistic resident centred care was provided. Information was provided to potential residents and family/whānau that ensured they were involved in decisions relating to their care.

Resident assessments informed care plan development. Care plans were implemented with input from the resident and family/whānau and contributed to achieving the resident's goals. Review of the care plans occurred regularly. Other health and disability services were engaged to support the resident as required. The activity programme supported the resident to maintain physical, social, and mental health aspirations.

Medicine management reflected best practice, and staff who administered medication were competent to do so. The discharge and /or transfer of residents was safely managed. The nurse practitioner stated the provision of care met the residents' needs.

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

Includes 2 subsections that support an outcome where Health and disability services are provided in a safe environment appropriate to the age and needs of the people receiving services that facilitates independence and meets the needs of people with disabilities.		Some subsections applicable to this service are partially attained and of low risk.

There was a current building warrant of fitness. There were two dual-purpose wings with single rooms and ensuites. These wings had accessible external areas for residents and their visitors, with shade and seating. The dementia unit had some single rooms and four shared bedrooms. There was a secure outdoor area around the perimeter of the unit.

There was an approved fire evacuation plan and implemented fire safety and emergency management policies and procedures. External areas were safe. Residents' rooms were of an appropriate size for the safe use of and manoeuvring of mobility aids and provision of care. Lounges and dining areas provided communal spaces for residents and their visitors. Communal and individual spaces were maintained at a comfortable temperature.

A call bell system was in place for residents to access help when required and these were observed to be answered promptly. Staff were trained in emergency procedures and there were sufficient supplies sighted to sustain residents and staff in the advent of an emergency.

There were security procedures in place to ensure the protection of residents, staff, and visitors.

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

Includes 5 subsections that support an outcome where Health and disability service providers' infection prevention (IP) and antimicrobial stewardship (AMS) strategies define a clear vision and purpose, with quality of care, welfare, and safety at the centre. The IP and AMS programmes are up to date and informed by evidence and are an expression of a strategy that seeks to maximise quality of care and minimise infection risk and adverse effects from antibiotic use, such as antimicrobial resistance.		Some subsections applicable to this service are partially attained and of medium or high risk and/or unattained and of low risk.

The organisation supported the safety of residents and staff via the infection prevention and antimicrobial stewardship programmes. The programmes were appropriate for the size, complexity, and type of service. The infection control coordinator and clinical

services manager were responsible for the implementation the programme. The infectious diseases/pandemic plan had been tested. Staff were educated in the principles of infection control. A surveillance programme was implemented that captured data relating to the type of infection.

Here taratahi | Restraint and seclusion

Includes 4 subsections that support outcomes where Services shall aim for a restraint and seclusion free environment, in which people's dignity and mana are maintained.		Subsections applicable to this service are fully attained.

Ultimate Care had policies and procedures that supported a restraint free environment and reflected best practice. Ultimate Care Oakdale had a philosophy and practice of no restraint. There were no restraints in use in the rest-home, hospital or dementia wing during the audit. Staff were provided annual training that focused on alternatives to restraint and de-escalation.

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	18	0	4	5	0	0
Criteria	0	156	0	7	4	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.

There may be subsections in this audit report with an attainment rating of 'not applicable' which relate to new requirements in Ngā Paerewa that the provider is working towards. The provider will be expected to meet these requirements at their next audit.

For more information on the standard, please click here.

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

Subsection with desired outcome	Attainment Rating	Audit Evidence
Subsection 1.1: Pae ora healthy futures Te Tiriti: Māori flourish and thrive in an environment that enables good health and wellbeing. As service providers: We work collaboratively to embrace, support, and encourage a Māori worldview of health and provide high-quality, equitable, and effective services for Māori framed by Te Tiriti o Waitangi.	FA	The Cultural Safety policy identified that the organisation fulfilled its commitment and obligations to Te Tiriti o Waitangi through working in partnership with residents/whānau to identify service options/approaches to achieve the aspirations of Māori. The organisation had a Māori health plan that recognised the principles of Te Tiriti o Waitangi and described how the Ultimate Care Group (UCG) responded to Māori cultural needs in relation to health and illness. Culturally safe practices for Māori residents were defined in the policy. Observation and interviews with staff, residents and family/whanau confirmed that service delivery was delivered in line with the requirements of the cultural safety policy. The Māori health plan outlined that the recruitment of Māori staff will be encouraged. There were several staff who identified as Māori. Cultural safety training was provided at orientation and through the mandatory annual education programme. It included Te Tiriti o Waitangi and tikanga best practice. All staff had completed the training. In addition, all registered nurses (RNs) were required to meet

		the New Zealand Nursing Council competencies regarding implementation of Te Tiriti o Waitangi in practice. The Māori health plan described the organisation's commitment to improving outcomes for tāngata whaikaha, by careful assessment and collaboration with the tāngata whaikaha and key partners when planning care. The plan and Cultural Safety policy described an approach to service delivery and cultural safety that was equity centred. The approach included but was not limited to recognising the importance of extended family/whānau and increasing cultural competence. Signage in te reo Māori was evidenced throughout the facility and key documents could be provided in te reo Māori if required. The facility had identified potential linkages within the local community as outlined in staff interviews. Contact details for key organisation's that UCG had links with such as Te Kōhao Health in Kirikiriroa for training talks and cultural advice on cultural matters, were available to the facility (refer to 3.1.6). At time of audit there were residents who identified as Māori residing in the facility.
Subsection 1.2: Ola manuia of Pacific peoples in Aotearoa The people: Pacific peoples in Aotearoa are entitled to live and enjoy good health and wellbeing. Te Tiriti: Pacific peoples acknowledge the mana whenua of Aotearoa as tuakana and commit to supporting them to achieve tino rangatiratanga. As service providers: We provide comprehensive and equitable health and disability services underpinned by Pacific worldviews and developed in collaboration with Pacific peoples for improved health outcomes.	FA	The Pacific plan outlined the organisation's commitment and policy to ensure that the provision of culturally safe care was provided to Pacific people. It did so by seeking to understand each individual resident who identified as a Pacific person, their family, their worldview and what this meant for planning and achieving quality service delivery and outcomes together. Information gathered during the admission process included identifying a resident's specific cultural needs, spiritual values, and beliefs and these were reflected in care planning. The Pacific Plan was informed by the Ola Manuia: Pacific Health and Wellbeing Action Plan 2020-2025. It required that resident assessments and care plans inform individualised culturally safe and appropriate care. It identified that staff work in partnership with residents identifying as Pacific peoples and their families to achieve equitable, culturally safe, high-quality care and described how this may be achieved. At the time of the audit, there were residents who identified as Pacific peoples.

		The organisation had an implemented strategy that ensured that a Pacific health and wellbeing workforce was recruited, retained, and trained across the organisation. There were no staff who identified as Pacific peoples at time of audit. Ultimate Care Group has links within the health care community and these included contacts for general assistance with issues related to Pacific Island Health and cultural advice.
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	Strategies to ensure that residents' rights were upheld in a manner that complied with Health and Disability Commission Code of Health and Disability Services Consumers' Rights (the Code), were embedded throughout policies and procedures. Staff received training on the Code at orientation and staff interviews confirmed awareness of the Code. Staff interviews and observation of service delivery confirmed that resident rights were upheld, including ensuring privacy was maintained when providing cares, providing choices, and promoting independence. Residents and family interviews verified that individual religious and social preferences, values and beliefs were identified and upheld. Residents and/or their family/whānau were provided information on the Code as part of their admission process. The information supplied included documentation on the complaints process and additional information for example for advocacy services. Residents and family/whānau confirmed that they were aware of, and understood, information regarding residents' rights. Posters in both English and te reo Māori were visible throughout the facility. Information on the Nationwide Health and Disability Advocacy Service was available in pamphlets within the facility. Contact details were also available for independent advocates. The advocacy policy described how advocacy would be provided and supported. This included providing the resident and family/whanau with opportunities for discussion about residents' rights and access to independent advocacy, recognising Māori mana motuhake (independence) and mana motuhake (self-determination).

		Policies and practice reflected that service's recognition of Māori mana motuhake that included ensuring that all residents including any Māori resident's right to independence was encouraged and upheld, ensuring the resident and their family/whānau were consulted and communicated with throughout the care planning process, and able to practise their own personal beliefs and values.
Subsection 1.4: I am treated with respect The People: I can be who I am when I am treated with dignity and respect. Te Tiriti: Service providers commit to Māori mana motuhake. As service providers: We provide services and support to people in a way that is inclusive and respects their identity and their experiences.	FA	Residents and family/whānau stated they were involved in care planning and provided with opportunities to share their individual religions, social preferences, values, and beliefs. This was confirmed in care planning documentation reviewed and staff interviews. Interviews with residents, and family/whānau and observation confirmed that the facility and staff were responsive to each resident's expression of identity. Residents were able to have some of their own personal pieces of furniture and memorabilia on display in their rooms and could choose what clothing and personal adornments they wore each day. Hairdressing services were available within the facility and residents were free to participate in their chosen church or social activities in the community. Policies and procedures to ensure each resident's right to privacy and dignity were upheld, were consistent with the requirements of the Privacy Act and Health Information Privacy Code. Interviews with residents and family/whānau and observations confirmed that resident privacy and dignity was respected during care provision. For example: permission was obtained from residents before entering their private space; doors were shut when personal cares were being provided; residents were suitably attired when taken to communal areas and conversations of a personal in nature were conducted in private (refer to 1.7.5). Staff received training in tikanga best practice. Activities incorporated national cultural celebrations when they occurred such as Waitangi Day and Matariki. Signage in the facility was in both te reo Māori and English. Staff completed Te Tiriti o Waitangi training at orientation. Interviews with staff identified an understanding of this and described how it was

		incorporated into day-to-day service delivery. The organisation responded to tāngata whaikaha needs. One example described by one staff member included being able to converse with a Māori resident in te reo Māori, when the resident wished.
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	The abuse and neglect policy included definitions, guidelines, and the responsibilities of staff to report any alleged or suspected abuse. Staff completed orientation and mandatory training in abuse and neglect. Interviews confirmed staff awareness of their obligations under the policy. Staff and family/whānau interviews described an environment free from abuse, neglect, or discrimination. The administration policy provided guidance for managing resident finances, through a centralised UCG system. The admission agreement provided clear expectations regarding management responsibilities of personal property and finances. Resident clothing was labelled and returned to the resident's room after laundering. Residents own furniture and memorabilia were observed to be treated respectfully by staff and others. Staff job descriptions sighted included the purpose of the role, responsibilities, and reporting lines. Staff were required to sign and abide by the UCG code of conduct and professional boundaries agreement. Staff files sighted evidenced that these were signed. Staff mandatory training included maintaining professional boundaries. Discussion with staff confirmed their understanding of professional boundaries relevant to their respective roles. Residents and family/whānau confirmed that staff were respectful and that professional boundaries were maintained. Residents and family/whānau described an environment in which there was no evidence of institutional and systemic racism. Family/whānau felt safe to engage in free and frank discussions with staff and could comfortably discuss any issues. Policy and procedure documentation described the Māori model of care Te Whare Tapa Wha as underpinning and informing service delivery.

Subsection 1.6: Effective communication occurs The people: I feel listened to and that what I say is valued, and I feel that all information exchanged contributes to enhancing my wellbeing. Te Tiriti: Services are easy to access and navigate and give clear and relevant health messages to Māori. As service providers: We listen and respect the voices of the people who use our services and effectively communicate with them about their choices.	FA	There was policy to ensure that residents and their whānau had the right to comprehensive information supplied in a way that was appropriate and considered specific language requirements and disabilities. Advocacy was available for those who required support to understand information. There was evidence in clinical files and interviews, that the service communicated in a timely manner with other agencies such as the GP, nurse practitioner (NP), physiotherapist, podiatrists, and specialist and hospital services. There was an open communication policy that required full disclosure in the event of an accident or incident. It required that family/whānau or enduring power of attorney (EPOA) are advised within 24 hours of an adverse event/incident involving a resident occurring. Review of incident and accident documentation confirmed that open disclosure occurred within the required timeframes. Family confirmed that they were notified of incidents as well as daily events such as GP visits. Interviews with family/whānau and observation of staff interactions with residents, confirmed that staff were respectful in their communications with residents and family/whānau and allowed time for discussions and decisions to take place. There was policy to ensure that where required, interpreters and cultural representatives/advocacy services would be accessed to ensure information was understood. Where required, interpreters were accessed from Te Whatu Ora Waikato. At time of audit there were no residents who required an interpreter. Three monthly resident/whānau meetings informed residents and their family/whānau of facility activities. Meetings were advertised in the activities planner with reminders of what was coming up placed on notice boards throughout the facility. Meeting minutes, plus staff and resident interviews confirmed attendance by both residents and their family/whānau. The meetings also offered participants an opportunity to provide feedback and make suggestions for improvement. Copies of the menu and activities plan were also made available to residents and their family/whānau on the notice board. Residents and their

		family/whānau were also kept informed of activities and events through a closed social media platform (refer to 1.7.5).
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.	PA Moderate	There was an informed consent policy to ensure that a resident who had the capacity/competence to consent to treatment or a procedure had been given sufficient information to enable them to arrive at a reasoned and voluntary decision. Staff received training on informed consent and informed choice during their orientation. All staff interviewed demonstrated an understanding of the informed consent process, including obtaining consent to provide daily cares. The resident admission pack included information regarding consent. A RN explained and discussed informed consent to residents and/or their family/whānau during the admission process to ensure understanding. This included consent for resuscitation and advanced directives. All resident files sighted had a signed informed consent form, however not all events were consented. The files of dementia residents sampled contained evidence that the GP had completed an assessment relating to the resident's capacity. Resuscitation status had been documented and discussed with family/whānau as confirmed during family/whānau interview. The dementia residents' files all held an activated EPoA, or a court appointed guardian. Resident files sampled contained advanced directives. The clinical services manager (CSM) and NP were aware the residents' advanced directives. The informed consent policy acknowledged Te Tiriti o Waitangi and the impact of culture and identity of the determinants of the health and wellbeing of Māori residents. It required health professionals to recognise these as relevant when issues of health care and Māori residents arose and provided the policy and process to be followed.

Subsection 1.8: I have the right to complain The people: I feel it is easy to make a complaint. When I complain I am taken seriously and receive a timely response. Te Tiriti: Māori and whānau are at the centre of the health and disability system, as active partners in improving the system and their care and support. As service providers: We have a fair, transparent, and equitable system in place to easily receive and resolve or escalate complaints in a manner that leads to quality improvement.	FA	Orientation for staff included the complaints process. The complaint process was made available and explained to residents and their family/whānau on admission to the facility. There was a current UCG complaints policy that reflected the requirements of Right 10 of the Code and the associated complaints process to follow in the advent of a complaint. It required that the complaint was acknowledged in writing within five working days of receipt, that the complainant was to be informed about progress on the complaint at intervals of not more than one month, and to advise the complainant of the outcome of the investigation into the complaint. There process included an electronic complaints' register to manage, record, and analyse any complaints made. The acting facility manager (FM) was responsible for managing complaints and advised that there had been no complaints made through the facility complaints system in the preceding two years. Complaint forms and a box to anonymously post a complaint were accessible within the facility. The UCG website enabled complaints to be logged online. Interviews with staff, residents, and family/whānau confirmed that residents and family/whānau were free to raise any concerns/issues directly with staff and were aware of the complaint process. Any issues could also be discussed at resident meetings. The cultural safety policy required that staff behave in a culturally sensitive manner. Internal and external cultural advisers were available to advocate on cultural issues on behalf of clients where there are complaints and conflicts. There was one complaint made to the Office of the Health and Disability Commissioner (HDC) regarding care provided. The HDC had reviewed the complaint and decided not to pursue it but requested that all complaints were followed up at audits.
Subsection 2.1: Governance The people: I trust the people governing the service to have the	FA	Ultimate Care Cambridge Oakdale is part of the Ultimate Care Group. Ultimate Care Group's board was the governance body, responsible for the provision of services at the facility. The board was aware of

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.		their responsibility to monitor the organisation's compliance with legislative, contractual, and regulatory requirements. Ultimate Care Group had a documented annually reviewed strategic plan, that detailed how the service would ensure equitable service delivery. The FM had been acting in the FM role for seven weeks, while the recruitment process for a permanent appointment was in progress. The FM had previous experience in similar acting roles for UCG. A CSM who had been in the role for over a year supported the FM. In addition, there was ongoing support from the UCG management team including the facility's regional manager who provided support throughout the audit process. There was a UCG wide quality and risk management system, supported by documented and implemented policies and processes. The organisation demonstrated leadership and commitment to the quality and risk management system through regular, ongoing assessment of the system through internal audits and review, staff training and orientation and analysis and reporting of key quality information. Key quality and risk information as well as annual business plan outcomes including health and safety and financial performance were routinely reported to, and monitored by, the Board. Policy and procedure documentation identifies that cultural advisory services will be sought where necessary, to ensure cultural needs are met and that resident culture and religion will not preclude them from equal opportunities and access to a quality service delivery. The organisation ensures that services improve outcomes and achieve equity for tāngata whaikaha people with disabilities through analysis of results of reviews of service delivery quality through audit monitoring activities, satisfaction surveys, and resident meetings. Regular surveys and resident meetings provide an opportunity for residents and family/whānau to provide input into the services and where relevant, participate in the planning, implementation, monitoring, and evaluation of service delivery. Interviews with a Board member confirmed that there was Māori representation, with well-established linkages in the Māori community, at a governance level. The chief executive described the core competencies that executive management are required to

		demonstrate, including an understanding the organisation's obligations under Te Tiriti o Waitangi, health equity, and cultural safety. The UCG provides a structured approach to clinical governance, through the clinical operations group, that is appropriate to the size and complexity of the organisation. The clinical operations group provides oversight and support to facilities on clinical matters and reports monthly to the board on key aspects of service delivery including, but not limited to, infection rates, falls, and incidents/accidents. The facility holds contracts with Te Whatu Ora Waikato for rest home, hospital, dementia, respite care, and day care services. The facility provided care for up to 47 residents with 16 beds being dementia specific and 31 being dual purpose/swing beds for either rest home or hospital level care. At time of audit there were 46 residents in the facility. Of these 22 were assessed as requiring hospital level care, and nine assessed as requiring rest home care. There were 15 residents assessed as requiring dementia level care in the secure dementia wing.
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	Ultimate Care Group had a current and implemented quality and risk management system, that provided a framework for continuous quality improvement. Interviews with senior staff describe executive commitment to quality and risk management. Staff were made aware of the outcome of quality activities through regular scheduled staff meetings. Meetings included, but were not limited to, discussions and updates on a range of relevant quality related topics, health and safety and infection prevention. Attendance at meetings was recorded. There was an implemented annual schedule of internal audits. Quality improvement processes were initiated for areas of noncompliance that included the development of a corrective action plan. However, these were not consistently completed. Results were analysed and trends monitored, with discussion at staff and quality meetings. Reporting from the facility through the facility 'managers reflective report' is a tool that enables collection, collation, and benchmarking of clinical information across all UCG facilities. Information was also made

		available for staff. There was policy and procedure to assist in identification of risk including internal risks such as risk to residents, clinical and safety risks, and health and safety. The quality and risk plan outlined the identified internal and external organisational risks for the organisation. There were implemented policies regarding open disclosure, managing adverse event, complaints and advocacy that were in line with the National Adverse Event Reporting Policy. Adverse event reporting was defined in policy and procedure, that detailed the requirements for external and internal reporting. There were documented and implemented health and safety systems in place. Staff completed health and safety training as part of orientation on commencement and in the schedule of mandatory training. Staff confirmed awareness of the incident and accident management and reporting procedure and forms were readily available in the facility. The operations manager confirmed that Section 31 notifications had been submitted for changes in management, including the CSM, the interim FM, and notifications for staffing deficits as per requirements. The organisation's commitment to providing high quality health care and equity for Māori is stated within the Māori health action plan and policy. This includes the provision of appropriate education for staff, supporting leaders to champion high quality health care and ensuring that resident centred values guide all clinical decisions. The UCG national programmes manager described the organisation's strategy to improve health equity. This included critical analysis of service user presentations and service performance indicators such as dementia, pressure injuries and diabetes and comparing these results for residents who identified as Māori or Pacific peoples against all UCG facilities. This data was utilised to inform staff training and education. Manager interviews described a strategy to follow-up enquiries about the facility, made by Māori and Pacific peoples, to identify why the service was not chosen and analyse this feedback from an equity lens, to improve access such as translating the pathway to funding access into to te reo Māori.

Subsection 2.3: Service management The people: Skilled, caring health care and support workers listen to me, provide personalised care, and treat me as a whole person. Te Tiriti: The delivery of high-quality health care that is culturally responsive to the needs and aspirations of Māori is achieved through the use of health equity and quality improvement tools. As service providers: We ensure our day-to-day operation is managed to deliver effective person-centred and whānau-centred services.	PA Low	There was a staffing policy that provided guidance to staff rostering to ensure the allocation of the appropriate skill mix and staff numbers to ensure safe levels of staffing. The facility was divided into three wings. The two dual purpose wings were co-located and divided by a reception area and offices. One wing, which included the nurses' office, was typically used for high acuity residents such at hospital level care. The other wing was for residents with a lower acuity. A third wing housed a secure dementia unit. A review of duty rosters confirmed that the facility manager was available on duty, Monday to Thursday inclusive. The CSM worked morning shifts Monday to Friday inclusive. There were six RNs employed and this ensured that all but one shift had RN cover. The Saturday morning shift had a non-RN shift lead, who was supported by the on-call CSM. At the time of audit there was a significant national health workforce shortage. In addition to the RN shifts, in the dementia wing there were two caregivers on morning and afternoon shifts and one on night shift Monday to Sunday inclusive. In the dual-purpose wings, each had two caregivers on morning and afternoon shifts and one caregiver across both wings on night shift Monday to Sunday inclusive. There were two diversional therapists working each day from Monday to Friday and an activities coordinator two days per week. Kitchen and laundry staff were rostered Monday to Sunday inclusive (refer to 5.5.3). All of the six currently employed RNs had completed interRAI training. The training schedule reviewed evidenced that all care givers had completed, or were about to complete, the Careerforce training to Level four, with all care givers working in the dementia wing completing appropriate dementia training. There was an implemented annual training programme that included mandatory requirements. The organisation had a documented role specific mandatory core training programme that included topics relevant to all services provided. Current cultural safety training and policy supported staff to develop health equity expertise and apply this to service delivery. Staff training attendance records sighted, and staff interviews confirmed that all staff completed their respective education

		requirements and competencies to meet the needs of residents equitably. The facility encourage staff to identify ethnicity and collected both staff and resident ethnicity data via the online platform that formed part of the monthly report compiled for the board. Support systems promotes staff wellbeing, and a positive work environment was confirmed in staff interviews. Employee support services were available as required.
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	There were current human resource management policies and procedures that were in line with good employment practice and met the requirements of legislation. An improvement is required regarding the collection of all the required staff recruitment information and the completion of performance reviews. The skills and knowledge required for each position were documented in the job descriptions and were in place for all staff relevant to their role. Professional qualifications were validated and there were systems in place to ensure that annual practising certificates and other health practitioners' certificates were current for all who required them. There was a documented and implemented orientation programme. Staff interviews and copies of individual orientation records evidenced that staff completed a role specific orientation covering the essential components of service delivery on induction. Staff information was maintained securely and confidentially in a locked cabinet in the FM's office. Staff records reviewed confirmed that ethnicity data was collected, recorded, and used in accordance with Health Information Standards Organisation requirements. The facility ensured that staff were provided with an opportunity to be involved in a debrief/discussions following significant events. Staff confirmed that ongoing support would be made available as required following incidents and events.

Subsection 2.5: Information The people: Service providers manage my information sensitively and in accordance with my wishes. Te Tiriti: Service providers collect, store, and use quality ethnicity data in order to achieve Māori health equity. As service provider: We ensure the collection, storage, and use of personal and health information of people using our services is accurate, sufficient, secure, accessible, and confidential.	FA	There was a current and implemented health records document policy to ensure that the health records were an accurate reflection of the interaction between the health care provider and the resident. Residents' records and medication charts were electronic. Access was password protected. Resident information and progress notes were entered accurately and in a timely manner in the records sampled. The name and designation of the person making the entry was identifiable. Residents' progress notes were completed each shift. The documented and implemented clinical records management policy ensured that only authorised people, who were entitled to view the information while providing and evaluating services to the resident, had access to them. Observation confirmed that resident information could not be viewed by unauthorised persons. In line with policy, residents' records were fully integrated and included relevant resident assessment information, and reports from other health professionals. The facility was not responsible for National Health Index registration of residents receiving services.
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 Low	Information about the service was available in printed format, and further information was available on the Eldernet website and the UCG website. The Needs Assessment Service Coordination agency (NASC) also held information about the service. A documented policy outlined the entry process. The CSM and FM worked in collaboration to co-ordinate the entry process with the resident and family/whānau. All residents admitted to the service required a NASC assessment and referral prior to admission. Confirmation of this process was seen in all clinical records sampled. A policy detailed the management for declining a resident and documented that a potential resident was not declined unless the care requirements were outside the scope of the service, or no bed was available. If no bed was available, a resident enquiry form was kept. This held relevant information, including the potential resident's ethnicity. The service offered the potential resident a bed when one

		became available. Potential residents and their family/whānau were kept updated regarding bed availability by the FM. Family/whānau confirmed this process occurred, and that the admission process was straightforward and respectful. Files sampled of dementia residents held specialist referral from a psychogeriatrician prior to admission, and consent for care was signed by the resident's EPoA, confirmed by family/whānau. Residents and family/whānau (including Māori), expressed satisfaction with the admission process and confirmed they were treated with dignity and respect. Although the Māori health plan described the organisation's commitment to improving outcomes for Māori, relationships with local Māori agencies to improve access and entry were still in development.
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.	FA	Residents had individualised support provided that met their physical, cultural, spiritual, and social dimensions of their wellbeing. Electronic clinical records sampled verified that RNs had completed all appropriate assessments and developed an individualised care-plan for all residents within the required timeframes. The documented assessments demonstrated that the resident's holistic wellbeing was considered on admission and included for example skin integrity, pain, falls risk, sleep patterns and behaviour. All interRAI assessments were current at the time of the audit, and clinical files sampled confirmed that interRAI assessments had been completed at least six monthly. Care-plans documented interventions to maintain and improve the residents' health and wellbeing. Progress notes, observations during the audit and interview with the resident's and their family/whānau, confirmed that assessments and care-plans had been developed in collaboration with the resident/whānau. Clinical files in the dementia wing (Whakahuia) included behaviour management plans. Potential behavioural triggers and interventions were documented. Staff described the potential triggers and how the triggers were avoided or minimised. They also discussed interventions suitable to de-escalate the resident's behaviour.

		Short term care plans were developed for acute conditions for example an infection or skin tear. These were updated as appropriate and signed off when the condition had resolved. Clinical records sampled were integrated including, for example, correspondence from community health providers, interRAI reports, the admission agreement, consent forms and a copy of the EPoA. A physiotherapist attended the service regularly and assessed new residents, reviewed residents six monthly, and/or following a fall and on the request of nursing staff, or when a change in the resident's mobility had been observed. Progress notes documented the resident's daily activities and any observed changes in health status or behaviour. The CSM, RN and staff stated that changes in a resident's behaviour were considered an early warning sign of a residents change in health status. Monthly vital signs and the weight of residents were documented. Where progress was different to that expected, or the resident had displayed signs or symptoms of illness, vital signs were documented, and further assessments were performed as appropriate. A RN developed a short-term care-plan and the GP, or NP were notified in a timely manner. Medical oversight of the residents was provided by a GP/NP partnership. The service received two visits per week, the GP visited one day per week, and the NP visited one day a week. The partnership provided a seven day/week twenty-four hour on call service. The NP was interviewed and confirmed that residents were seen and assessed at least every three months. If the resident's condition changed between times the CSM notified the GP/NP and a medical review was provided. This was confirmed in clinical records sampled. The NP stated that the residents received effective and responsive care that was provided in a manner which maintained their dignity and cultural needs. The NP also advised that residents were often seen more frequently than three months, and this enabled early diagnosis and treatment of health issues. It was stated that this action reduced the incidence of complications to the residents' health status and avoided multiple referrals to the public hospital.

		A shift handover was observed and followed recommended best practice guidelines. Records sampled of Māori residents confirmed that cultural preferences were incorporated into the care plan. The records also verified that residents and whānau were involved in identifying their own pae ora outcomes. Residents and whānau stated that care was provided in a manner that respected their mana. The national clinical services manager advised that the organisation had engaged with Māori and tāngata whaikaha to support service development.
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. 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.	FA	Two diversional therapists (DT) were employed. One planned and delivered the programme to the rest-home and hospital residents; the second DT planned and delivered the programme to residents in the dementia wing (Whakahuia). An activities assistant was available two days a week to support the DTs. The activities weekly programme was sighted on display throughout the hospital, rest-home, and dementia wings. The activities staff were interviewed and discussed the programme, which included a wide range of activities suitable for the residents. The activities programme promoted physical, social, cultural and intellectual skills in the rest-home, hospital and dementia services. Outings to the community occurred regularly for exercise activities, morning teas, and as available for other activities. Family/whānau also took residents into the community to attend celebrations and events. Implementation of the programme was observed during the audit and residents were seen to be engaged and having fun. Individual activities were available; for example, puzzles, colouring in and reading. Clinical files sampled confirmed that assessments of the resident's life skills and experiences were considered in the development of the activities care-plan. There was evidence that family/whānau had been engaged in the assessment and planning of the activities care plan, and this was verified by family/whānau. Care-plans of residents in Whakahuia documented activities that were

		suitable for the resident 24 hours of the day and acknowledged the resident's life experiences. The care-plans also included interventions to manage behavioural challenges for example de-escalation and diversion techniques. Māori celebrations and activities were woven into the programme, examples included having te reo Māori word quizzes, and having school kapa haka groups perform. The DTs and the DT assistant described connections they had with the Māori community. These connections had broadened their knowledge of te ao Māori and facilitated the promotion of Māori health needs and aspirations within the service. Residents and family/whānau confirmed satisfaction with the programme and stated it enhanced well-being.
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 Low	The medication management system reflected current recommended best practice. An electronic programme was used for the prescribing and recording of the administration of medication. Medications were dispensed by the pharmacy using a pre-packaged system. The pharmacy delivered medications daily and disposed of unwanted medications. A RN checked the medications prior to being placed in the medication trolley. Medication administration was performed by RNs and/or level four health care assistants who had completed the medication competency programme. A medication round was observed, and staff demonstrated competency administrating medication. Eye drops, ointments and creams had a documented opening date. During the audit no medications were observed to be out of date. The medication room was locked and inaccessible to unauthorised persons. Controlled medications were stored appropriately and documentation of these reflected legislative requirements. Although the medication fridge was temperature monitored, the medication room was not. All medication prescriptions were completed as per regulations, including the documentation of allergies and sensitivities. The GP/NP

		had reviewed the medication chart every three months or more frequently as required. Standing orders were not used in this service. Over the counter medications (OTC) were discussed with the resident and family/whānau by the GP/NP. Any OTC medications had been prescribed and were administered by staff. This was confirmed by observation and by resident and family/whānau. There were no residents self-administering medication during the audit. The medication policy provided a procedure that ensured, that should a resident wish to self-administer, a safe process would be implemented. The process was discussed by the CSM and the NP. Residents, including Māori residents and their whānau, were supported to understand and their medications, and this was confirmed by residents and whānau. The incident register confirmed that medication incidents were uncommon. When an incident did occur the CSM reviewed the factors that contributed to the incident and implemented a corrective action. The NP stated that the medication system and processes were safe and appropriate to the service. The CSM completed monthly medication audits including for example, resident photos were current and the effectiveness of pro re nata (PRN) medication was documented.
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 clinical files contained a documented dietary assessment completed for each resident on admission. This included allergies, special requirements likes and dislikes. There was evidence that the dietary needs of the resident were reviewed six monthly, or more often if required. There was one cook and two kitchen hands who provided all meals to patients. Interview with kitchen staff described how dietary requirements, including likes and dislikes, were conveyed to the kitchen by the nursing staff and diets are modified accordingly. The cook explained that information gathered at admission, regarding the food preferences of Māori residents, would be conveyed to kitchen

		staff, who could prepare Māori kai when requested. Residents had the opportunity to be engaged in food preparation through activities and some were observed to assist with setting tables. Residents were able to sit at set tables alongside other residents that they had formed friendships/dining routines with. The nutritional values of meals were reviewed and approved by a New Zealand Registered Dietician to ensure that they met the recognised nutritional guidelines for older people. A food control plan had recently been implemented. A corrective action arising from the review included that kitchen staff had not completed recent food safety training. All staff had subsequently enrolled for this. The temperature of food was monitored throughout the cooking and serving process. Fridge and freezer temperatures were monitored and documented. Food storge was safe and hygienic and appropriately labelled and rotated. Residents were observed to be given sufficient time to eat their meal and those who required assistance were provided with support in a dignified manner. Food waste was managed safely and covered to deter rodents. There were documented and implemented kitchen cleaning schedules (sighted). The kitchen and equipment were observed to be clean and tidy. Discussion and feedback on the menu and food occurs at the residents' meetings. Meal services observed and discussion with residents confirmed satisfaction with the variety and quantity of their meals. The dementia unit had access to fresh sandwiches and other snack food twenty-four hours per day.
Subsection 3.6: Transition, transfer, and discharge	FA	The transfer and discharge policy provided clear details regarding the

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.		transfer and discharge of residents in a safe and timely manner. The CSM described the policy. Discharge was planned and facilitated with the resident and family/whānau involvement when a resident's health status was observed to be changing. The CSM and the GP/NP liaised to ensure appropriate care was provided as the residents needs changed. Family/whānau were informed, and discussion occurred regarding the care requirements of the resident and ongoing care provision options. An interRAI assessment that reflected the current care needs of the resident, was provided to the NASC. Upon discharge the CSM provided relevant information to the new service provider. This process was verified by the NP and a family/ whānau member, who had experienced the process. Acute transfers to the public hospital occurred when there was a sudden change in a resident's health status and the RN and/or the GP/NP determined the resident required specialised care. The national 'yellow envelope' system was used. In the envelope was included a hospital transfer letter which was generated by the electronic clinical record system. The letter included all relevant information and the last three entries of the progress notes. The resident's medication record was also printed and included in the envelope. The family/whānau were notified of the resident's need to transfer to the hospital. Patients and family/whānau were provided information about other health and disability services when indicated or requested, (confirmed by family whānau).
Subsection 4.1: The facility The people: I feel the environment is designed in a way that is safe and is sensitive to my needs. I am able to enter, exit, and move around the environment freely and safely. Te Tiriti: The environment and setting are designed to be Māori-centred and culturally safe for Māori and whānau. As service providers: Our physical environment is safe, well maintained, tidy, and comfortable and accessible, and the people	PA Low	A current building warrant of fitness was displayed at the entrance to the facility. There was an organisation wide schedule to ensure that electrical testing and tagging and the checking and calibration of bio-medical equipment was completed. All equipment sighted showed evidence of current testing. The facility had a preventative and reactive maintenance schedule. This included ongoing regular checks of systems, plant, and equipment. Interview with the maintenance person confirmed that there was a system to record the temperature of

we deliver services to can move independently and freely throughout. The physical environment optimises people's sense of belonging, independence, interaction, and function.		the hot water at regular intervals. However, this was not fully implemented (refer to 2.2.3). There was routine maintenance of the facility van through a local garage. The vehicle had a current registration, warrant of fitness, first aid kit, fire extinguisher, and a functioning hoist. Staff interviews, and documentation confirmed that those who drove the van had a current driver's licence and first aid certificate. Staff identified maintenance issues via an electronic system. Staff described the process for requisitioning maintenance or repairs and stated that these were undertaken in a timely manner. This was confirmed on a review of the electronic maintenance log. However not all maintenance tasks had been logged (refer to 2.2.3). Urgent maintenance requests were managed by the UCG 'help line'. There was a current maintenance register in place, that included generic UCG organisation wide hazards as well as facility specific hazards. Signage throughout the facility was clear and included signage in te reo Māori. All communal showers and toilets had a system to indicate vacancy and call bells were in place to summon assistance. All areas, including residents' rooms provided disability access that could be accessed freely with mobility aids. Residents' spaces had sufficient room, handrails, and other equipment to facilitate mobility with assistance if required and promote safety and independence. Wall panel heaters were noted to be too hot to touch (refer 4.1.2). The dual-purpose wings had accessible external areas for residents and their visitors with some shade and seating suitable for use in summer months. For privacy residents could meet with visitors in their rooms, and rooms had sufficient seating provided for this purpose. In the 18-bed dementia unit there were four shared double rooms with curtains dividing each bed space. All other dementia bedrooms were single rooms. There was a large, shared dining room and lounge and a small seating area in the corridor, opposite communal toilets for residents to sit away from others, but no other private space (refer 4.1.3). The dementia unit had access to a safe, secure external garden around the perimeter of the unit. All resident rooms in the dual-purpose wings are single and had

		ensuite bathrooms. There were two shared bathrooms for residents in the dementia wing. There were sufficient toilet facilities available for staff and visitors close to the facility entrance. All residents' bedrooms and communal areas accessed by residents had access to adequate ventilation with at least one external window providing natural light. In some areas heat pumps provided heating in the winter and cooling in the summer. In other areas, including the dementia unit wall panel heaters were in use. The environment in resident areas was noted to be maintained at a satisfactory temperature. This was confirmed by staff, residents, and family/whānau interviews. Staff interview confirmed that the UCG as an organisation would facilitate Māori consultation and co-design, should any new buildings or services be considered. There had been no alterations to the facility nor any planned.
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	An approved fire evacuation plan was sighted. There was a sprinkler system and smoke alarms installed. There was sufficient firefighting equipment sighted throughout the facility. Exit signage was clearly displayed and illuminated. Training records evidenced that staff complete emergency and disaster procedures plus fire safety training as part of orientation and the mandatory training programme. Emergency evacuations were documented and had occurred the day prior to the audit. Training and education records, plus staff interviews confirm that fire wardens received fire warden training and staff have undertaken emergency evacuation training. The staff competency register evidenced that there is a system to ensure that staff maintain first aid competency. There were functioning call bells sighted in all patient areas including residents' rooms, ensuites, and communal areas. There was a system to check the functionality of all call bells as part of routine checks completed by the maintenance person. However, these checks were not documented consistently (refer to 2. 2.3). Observation noted that

		when call bells were activated these were responded to promptly. There were sufficient supplies sighted to sustain residents and staff in an emergency. There was an agreement with a local supplier (sighted) to provide a generator in the advent of power failure and functional torches were easily accessible throughout the facility. There was a gas barbeque, emergency and enough store cupboard food items and water. In addition, there were sufficient supplies of dressings, and continence supplies. The facility's emergency plan included considerations of different levels of resident needs. There were security procedures in place to ensure the protection of residents, staff, and visitors. These included visitors signing in and out, staff wearing name badges, security lighting and restricted access to the facility afterhours with visitors needing to ring the doorbell to gain entry. The emergency and security arrangements were explained to residents and family/whanau on admission, in drills and in resident meetings.
Subsection 5.1: Governance The people: I trust the service provider shows competent leadership to manage my risk of infection and use antimicrobials appropriately. Te Tiriti: Monitoring of equity for Māori is an important component of IP and AMS programme governance. As service providers: Our governance is accountable for ensuring the IP and AMS needs of our service are being met, and we participate in national and regional IP and AMS programmes and respond to relevant issues of national and regional concern.	FA	The organisation's executive demonstrated that infection prevention programme (IP) and antimicrobial stewardship (AMS) was integral to delivering a safe and high-quality service by purchasing an infection control programme from a specialist provider. The CSM discussed ongoing support provided that had been, and will continue, to be provided to the organisation as required, by the specialist provider. The CSM collated a monthly infection report which was reported to the executive leadership team. Infection prevention events were notified immediately to the national clinical services manager. Policies and procedures directed the management of the event using a stepwise approach and a multidisciplinary team approach was initiated, for example the general practitioner, the clinical coach, regional manager, infectious diseases team were involved as appropriate.
Subsection 5.2: The infection prevention programme and implementation The people: I trust my provider is committed to implementing	FA	The IP programme implemented was suitable for the size and scope of the service provided. The programme was co-ordinated by a RN (infection control co-ordinator) with a position description, and suitable

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.		training in infection control. The CSM described ongoing education attended related to IP and AMS. The infection control coordinator (ICC) worked in collaboration with the CSM, and they held the responsibility for decision making including overseeing and implementing, monitoring, and reporting of the IP programme. Both staff members had access to the clinical records and diagnostic results of residents. The CSM's line of report was to the national clinical services manager, who was a member of the executive team. Procurement, building modifications, and other relevant policies and procedures were implemented following consultation with the CSM and the ICC and the national clinical services manager. The IP programme, policies and procedures met requirements of this standard and reflected best practice. The programme had been reviewed annually, and monthly reports were provided to the executive team by the CSM. Infection control was discussed at monthly staff and quality meetings. This was confirmed by staff. Policies and procedures were available for all staff to access. Staff confirmed knowledge of these policies and discussed how they accessed them. A current pandemic/infectious diseases response plan was documented and had been regularly tested. Sufficient supplies of infection prevention resources and personal protective equipment (PPE) was available. Hand basins and hand sanitisers were readily available throughout the service. Signage pertaining to hand hygiene was sighted during the audit. Annual organisational infection prevention education was provided to all staff, verified by education records sighted and staff interviews. In addition, education was provided at staff meetings relating to current trends, for example management of residents with a urinary tract infection. Staff discussed these additional education sessions. The ICC and the CSM, had completed additional IP education delivered by an IP practitioner. Single use devices were not reused, this was verified during staff interviews and by observation during the audit. Reusable shared equipment for example sphygmomanometers, thermometers, and dressing scissors were decontaminated appropriately as per policy and the manufacturers recommendations. Appropriate materials for this process were observed during the audit, and staff discussed the

		procedure. A sanitiser was in the sluice room, and bedpans and urinals were sanitised after each use. The IP programme had a section relating to Māori cultural values. The section reflected the spirit of Te Tiriti O Waitangi and provided guidance to staff to ensure culturally safe practice. Staff interviewed confirmed they were aware of the policy, and provided examples of how culturally safe practices were implemented. Where educational resources were required to be given to residents in te reo Māori, staff and/or family/whānau were used to speak te reo Māori to the resident. Written information was accessible via the HealthEd website. Patients and family/whānau confirmed that staff had discussed with them infection control issues and precautions.
Subsection 5.3: Antimicrobial stewardship (AMS) programme and implementation The people: I trust that my service provider is committed to responsible antimicrobial use. Te Tiriti: The antimicrobial stewardship programme is culturally safe and easy to access, and messages are clear and relevant. As service providers: We promote responsible antimicrobials prescribing and implement an AMS programme that is appropriate to the needs, size, and scope of our services.	FA	There was an implemented antimicrobial policy that was appropriate to the size scope and complexity of the service. The policy had been approved by the organisation and was a component of the IP programme. Monthly reports were sighted that reported the number and type of infections, with an analysis that included the antibiotic course prescribed, and the causative organism identified by laboratory report where appropriate. The reports were reviewed by the CSM and the national clinical services manager to identify trends, or/and opportunities to reduce antimicrobial prescribing. The NP confirmed antibiotic prescribing occurred as per best practice guidelines sourced from Best Practice Advocacy Centre New Zealand (BPAC), and laboratory services. Clinical staff had access to laboratory reports. Residents known to have been positive for a multidrug-resistant organism (MDRO) had this documented in their clinical file.
Subsection 5.4: Surveillance of health care-associated infection (HAI) The people: My health and progress are monitored as part of the	PA Moderate	Surveillance of health care-associated infections was appropriate to the size and type of service. The surveillance programme was documented, and standard definitions were used relating to the type of

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.		infection acquired. Monthly surveillance data was collected and reported to the executive team, however not all required detail was included in the data. Trends and opportunities to improve were considered by the CSM, ICC and the national clinical services manager. There were no trends identified in IPC documents sampled. The reports were discussed at staff meetings, and this was verified by staff. The NP stated the service cared for residents in a manner that reduced the rate of infection, and any residents with signs and symptoms of infection were reviewed in a timely manner. Residents who developed an infection were informed and family/whānau were advised. The process was culturally appropriate, and this was confirmed by residents and family/whānau. The most recent infection outbreak was in November 2022, five residents developed COVID 19. The outbreak lasted two weeks.
Subsection 5.5: Environment The people: I trust health care and support workers to maintain a hygienic environment. My feedback is sought on cleanliness within the environment. Te Tiriti: Māori are assured that culturally safe and appropriate decisions are made in relation to infection prevention and environment. Communication about the environment is culturally safe and easily accessible. As service providers: We deliver services in a clean, hygienic environment that facilitates the prevention of infection and transmission of antimicrobialresistant organisms.	PA Moderate	There was a documented and implemented policy and associated procedures to guide the safe and appropriate storage and disposal of waste and infectious or hazardous substances that complied with legislation and local authority requirements. Cleaning products and other hazardous substances were sighted to be stored safely. Current material safety data information sheets were available to staff in relevant locations such as the laundry, kitchen, and the sluice room. The annual training programme included chemical safety, waste management and infection prevention. Sharps containers were appropriately placed in clinical areas visited. Interviews and observations confirmed that there is enough PPE available, and observation confirmed that this was used correctly. There were documented cleaning processes and schedules. However, cleaning staff were not consistently available. Laundry services were rostered seven days a week, on day shifts. In evenings caregivers undertook any outstanding laundry. Appropriately

		colour coded linen bags were used to collect and store linen safely. There was an implemented process clearly delineating the clean and dirty flow of laundry. There were documented processes for the safe and hygienic decontamination washing, drying, and handling of personal clothes. Interviews with laundry staff and observation confirmed knowledge and implementation of processes, including infectious linen. Linen was laundered by an off-site service; clean linen was transported in covered trollies and unpacked into linen cupboard. Residents' clothing was labelled and returned to the resident's room once laundered. Residents and family/whānau interviews confirmed satisfaction with laundry services. In the advent of building construction or renovation oversight and input would be provided by the infection prevention team.
Subsection 6.1: A process of restraint The people: I trust the service provider is committed to improving policies, systems, and processes to ensure I am free from restrictions. Te Tiriti: Service providers work in partnership with Māori to ensure services are mana enhancing and use least restrictive practices. As service providers: We demonstrate the rationale for the use of restraint in the context of aiming for elimination.	FA	The organisation had a policy that documented that the organisation's services were committed to being restraint free. The policy met all requirements of this standard. Staff were trained at least annually in de-escalation techniques, and this was confirmed by education records and during staff interviews. The policy documented that a RN, GP, the national restraint coordinator, and the resident's EPoA, (or substitute), must approve the use of the restraint prior to implementation. The national restraint coordinator is the executive leader responsible for ensuring a restraint free service is maintained. Ultimate Care Cambridge Oakdale was a restraint free service. No restraints were in use during the audit, this was confirmed by observation, staff, clinical records, the NP, the FM, CSM and family/whānau interviewed. Monthly reports by the CSM to the national clinical manager confirmed that no restraints were used in the service. Observation of the dementia unit during the audit, verified that no restraints were in use. Staff provided examples of activities and distractions that are used to maintain a restraint free environment.

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 1.7.5 I shall give informed consent in accordance with the Code of Health and Disability Services Consumers' Rights and operating policies.	PA Moderate	All resident files sighted included completed consent forms. However, the consents sighted did not include consent for outings or the use of photos/videos on social media. The sample size for consent forms was increased to review consent forms for six residents who had appeared on a closed social media platform. These consents did not include consent to the use of personal information on the platform.	i) Resident consent forms did not include consent to outings. ii) Use of resident information on a closed social media platform did not comply with the Privacy Act.	Ensure consent to all activities and the sharing/use of personal data is obtained 60 days
Criterion 2.2.3 Service providers shall evaluate progress against quality outcomes.	PA Moderate	Quality activities included a range of activities. However, there was inconsistent evidence to confirm that all activities had occurred as scheduled such as meetings, monitoring of hot water temperatures, call bell testing, and accident and incident reporting. Not all quality activities such as resident surveys and action points identified in	i) There was insufficient evidence that quality activities had occurred consistently as scheduled.	Ensure that all quality activities: i) Are consistently completed and recorded. ii) Evidence

		meetings, demonstrated that a quality review, evaluation, and implementation had been undertaken with sign off when completed. Results were analysed and trends monitored, with discussion at staff and quality meetings.	ii) Corrective actions did not consistently demonstrate progress towards achieving quality outcomes.	evaluation of progress towards quality outcomes. 90 days
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 were six RNs employed and this ensured that all but one shift had RN cover. The Saturday morning shift did not have an RN on duty. Strategies to mitigate risk in the absence of RN cover, included: the shift being filled by a shift lead who was a senior caregiver, and the availability of the CSM on-call to provide support on these shifts. Appropriate notifications had occurred for staff shortages. Recruitment processes were underway for additional RN resource. At the time of audit there was a significant national health workforce shortage.	There was one shift each week that did not have RN cover.	Ensure all shifts have at least one RN on duty. 60 days
Criterion 2.4.1 Service providers shall develop and implement policies and procedures in accordance with good employment practice and meet the requirements of legislation.	PA Moderate	Staff files reviewed demonstrated that recruitment processes for all staff include reference checks; identification verification; residency status where appropriate, and a position specific job description. However, evidence of police vetting, and a signed employment agreement was inconsistent. The sample size was increased to nine and demonstrated that four of nine files did not evidence a police check, and seven of nine did not have a signed employment agreement.	A police check and signed employment agreement was not available for all staff.	Ensure all staff have a current police check and signed employment agreement. 90 days
Criterion 2.4.5 Health care and support workers shall have the opportunity to discuss	PA Low	There was a documented process for performance appraisal that were to be completed annually. However, three of nine staff files did not evidence a current performance review. The FM was aware of	Not all performance reviews were current.	Complete outstanding performance

and review performance at defined intervals.		the short fall and had completed many outstanding reviews, with a strategy implemented to complete all outstanding reviews with a month.		reviews. 90 days
Criterion 3.1.6 Prior to a Māori individual and whānau entry, service providers shall: (a) Develop meaningful partnerships with Māori communities and organisations to benefit Māori individuals and whānau; (b) Work with Māori health practitioners, traditional Māori healers, and organisations to benefit Māori individuals and whānau.	PA Low	Some staff described relationships they were developing with individual Māori kaumātua; and other connections that were being developed to expand the service's partnership with Māori. The staff discussed that the objective of the developing relationship was to improve Māori individuals and whānau access and entry to the service. There was, however, no evidence of the service having meaningful partnerships with Māori organisations that benefited Māori individuals and whānau. In addition, there was no evidence that the organisation or management had supported the staff to establish relationships with Māori health providers or communities.	There are no developed partnerships with Māori community organisations.	Ensure partnerships are developed with Māori community agencies. 180 days
Criterion 3.4.2 The following aspects of the system shall be performed and communicated to people by registered health professionals operating within their role and scope of practice: prescribing, dispensing, reconciliation, and review.	PA Low	Although thermometers and temperature recording charts had been placed in the medication room, the temperature was not recorded consistently.	The medication room temperature was not consistently recorded.	Ensure the medication room temperature is consistently recorded. 90 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	All areas sighted provided for safe mobilisation for residents. However, wall panel heaters used for heating in both the rest home and dementia wings were noted to be set on high and contact could not be sustained for more than a few seconds, without burning.	Panel heaters in resident areas were too hot should a resident come in contact with these.	Ensure heaters used in resident areas do not exceed safe temperatures.

				60 days
Criterion 4.1.3 There shall be adequate personal space that is safe and age appropriate, and has accessible areas to meet relaxation, activity, lounge, and dining needs.	PA Low	Most residents had single rooms. However, there were four shared bedrooms in the dementia unit and there was no quiet, low stimulus area available that provided privacy when required for these residents in line with the provider's agreement with their funder.	Residents in share bedrooms do not have access to areas that provide privacy.	Ensure quiet, low stimulus areas are provided for residents in shared rooms. 180 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 Low	Although surveillance reports documented the residents name, national health index (NHI) number and other relevant data, the resident's ethnicity was not included on the report.	Surveillance reports do not include the resident's ethnicity.	Ensure surveillance reports include the resident's ethnicity. 180 days
Criterion 5.5.3 Service providers shall ensure that the environment is clean and there are safe and effective cleaning processes appropriate to the size and scope of the health and disability service that shall include: (a) Methods, frequency, and materials used for cleaning processes; (b) Cleaning processes that are monitored for effectiveness and audit, and feedback on performance is provided to the cleaning team; (c) Access to designated areas for the safe and hygienic storage of cleaning equipment and chemicals. This shall be reflected in a written	PA Moderate	All staff contributed to the cleaning as required, for example, night caregivers mopped the floors in the dementia wing. There was a vacant position for a cleaner at the time of the audit, consequently the facility was being cleaned five days per week. This had resulted in the facility not having all the daily cleaning tasks completed throughout the facility. For example, on some days the dementia unit did not receive a full daily clean. On the days of the audit, the auditors noted that the carpet in the dementia unit required cleaning and deodorising. Although education records confirmed that the cleaner had attended cleaning product orientation, the cleaner reported inadequate orientation to the cleaning products and procedures.	The cleaning processes were not appropriate for the size and scope of the service.	Ensure the cleaning processes are appropriate for the size and scope of the service. 90 days

policy.				

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 of this audit.

No data to display

End of the report.