The Ultimate Care Group Limited - Ultimate Care Churtonleigh

Introduction

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

The audit has been conducted by 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 Churtonleigh
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 19 September 2023 End date: 20 September 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: 31

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 fully attained with some subsections exceeded
	No short falls	Subsections applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some subsections applicable to this service partially attained and of low risk

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

General overview of the audit

Ultimate Care Churtonleigh is part of Ultimate Care Group Limited. It is certified to provide services for up to 36 residents requiring rest home, and hospital (geriatric and medical) level care. On day of audit 31 beds were occupied. The facility was managed by a facility manager, and a clinical services manager. The facility manager had been appointed since the last audit and had been in the role for three months. There have been no other changes to the organisation or within the facility.

This surveillance audit was conducted against the Ngā Paerewa Health and Disability Services Standard NZS8134:2021 and the providers contracts with Te Whatu Ora – Capital, Coast and Hutt Valley.

The audit process included review of policies and procedures, review of resident and staff records, observations and interviews with residents, whānau, management, staff, the national programmes manager and a general practitioner.

Previous areas identified as requiring improvement related to quality and risk management systems, medication management, and facility specifications are now fully attained. The previously identified area requiring improvement related to service provider availability remains partially closed.

Additional areas identified as requiring improvement relate to infection surveillance reporting data.

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.		Subsections applicable to this service fully attained.

There were policies and procedures to support staff in delivering culturally safe care. Staff received training in Te Tiriti o Waitangi.

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. The provider had a culture of open disclosure.

Care plans accommodated the choices of residents and their whānau.

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

Ultimate Care Group Limited was the governing body responsible for the services provided at this facility and understood their responsibilities to the Te Tiriti o Waitangi. The organisation's mission statement was documented and displayed. The service had a current business and a quality and risk management plan.

A facility manager ensured the management of the facility. A clinical services manager oversaw the clinical and care services. A regional manager (acting) supported the facility manager in their role.

At the time this audit was undertaken there was a significant national health workforce shortage. Findings in this audit relating to staff shortages should be read in context of this national shortage.

Quality and risk management systems were in place. Meetings were held that included reporting on various clinical indicators, quality and risk issues, and the review of identified trends. There were human resource policies that guided practice in relation to recruitment, orientation, and management of staff.

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.		Subsections applicable to this service fully attained.

Registered nurses assess residents on admission with input from the resident and/or whānau. The initial care plan guides care and service provision during the first three weeks after the resident's admission.

InterRAI assessments were used to identify residents' needs, and these were completed within the required timeframes. The general practitioner completes a medical assessment on admission and reviews occur thereafter on a regular basis.

Long term care plans are developed and implemented within the required timeframes. Residents' files reviewed demonstrated evaluations were completed at least six-monthly.

Residents who identified as Māori had their needs met in a manner that respected their cultural values and beliefs.

Handovers between shifts guided continuity of care and teamwork was encouraged.

The activity programme was managed by a diversional therapist. The programme provides residents with a variety of individual and group activities and maintains their links with the community.

An electronic medication management system was in place. Medications were administered by the registered nurses, and care givers who have completed current medication competency requirements.

The food service meets the nutritional needs of the residents. Meals are prepared on-site. Residents and family confirmed satisfaction with meals provided.

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.		Subsections applicable to this service fully attained.

There was a current building warrant of fitness. The building, plant, and equipment was fit for purpose and complied with relevant legislation to the health and disability service being provided. A reactive and preventative maintenance schedule was implemented. Areas were provided throughout the facility that enabled residents to meet with visitors in private and participate in cultural activities.

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 partially attained and of low risk.

The clinical services manager leads the infection control programme. Organisational COVID-19 prevention strategies were in place including a pandemic plan. One COVID-19 outbreak had occurred since the last audit, and this was managed according to internal policy, contract, and reporting requirements. Infection data was collated, analysed, trended, and reported to staff and the board.

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 fully attained.

Restraint minimisation and safe practice policies and procedures were in place. Restraint was overseen by the Ultimate Care group clinical lead and by the Churtonleigh clinical services manager. Information related to restraint was available at a governance level and to facility staff. Staff completed restraint elimination and safe practice training. There were no residents using restraint on the day of the audit. Restraint was only used as a last resort when all other options had been explored.

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	16	0	1	1	0	0
Criteria	0	50	0	1	1	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	Staff receive training in cultural safety at orientation. The organisation had developed a cultural safety module that was provided as part of the mandatory annual education programme. It defined and explained cultural safety and its importance, including Te Tiriti o Waitangi and tikanga best practice. Staff interviewed outlined how they ensure that cultural safety and tikanga best practice were embedded in care delivery. Current staff had completed training except staff who were completing orientation. The organisation had a Māori health action plan that recognised the principles of Te Tiriti o Waitangi and described how Ultimate Care Group (UCG) responded to Māori cultural needs in relation to self-determination, independence and autonomy. Māori residents interviewed stated they were involved in decision making and care was respectful of their cultural needs. There were residents who identified as Māori residing in the facility at time of audit.

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 to providing culturally safe care and defined the cultural and spiritual beliefs of Pacific peoples. The policy was underpinned by Pacific models of care with UCG senior staff accessing information to support the plan from Pacific communities. Further discussion with UCG staff involved in the creation of the Pacific plan provided examples of how the plan was being implemented as a pilot in another facility for their Pacific residents.
Subsection 1.3: My rights during service delivery The People: My rights have meaningful effect through the actions and behaviours of others. Te Tiriti:Service providers recognise Māori mana motuhake (self-determination). As service providers: We provide services and support to people in a way that upholds their rights and complies with legal requirements.	FA	The Code of Health and Disability Services Consumers' Rights (the Code) was on display in each wing of the facility, written in English and te reo Māori. Education records confirmed that staff had completed training that covered the Code. Staff discussed the Code and provided examples of how they met the Code when providing day to day care. Observation during the audit confirmed that care was provided in accordance with the Code. Residents and whānau were provided written information about the Code on admission and confirmed they were provided opportunities to discuss their rights.
Subsection 1.5: I am protected from abuse The People: I feel safe and protected from abuse. Te Tiriti: Service providers provide culturally and clinically safe services for Māori, so they feel safe and are protected from abuse. As service providers: We ensure the people using our services are safe and protected from abuse.	FA	There was policy that included definitions, guidelines, and responsibilities for staff to report alleged or suspected abuse. Staff received orientation and mandatory training in abuse and neglect. Interviews confirmed staff awareness of their obligations to report any incidences of suspected abuse. Staff, resident, and whānau interviews evidenced that there was no evidence of abuse or neglect. The admission agreement signed prior to occupation provided clear expectations regarding management responsibilities of personal property and finances. Residents and/or their whānau provided consent for the administrator to manage residents comfort funds. Staff interview and review of documentation evidenced that appropriate systems were in place that ensures the safe management of residents' comfort funds. Residents and/or their whānau provided further confirmation that residents' property

		was respected. Staff resident, and whānau interviews evidenced that the provider promoted an environment that provided a safe place for all to raise questions or concerns and that discussions were free and open.
Subsection 1.7: I am informed and able to make choices The people: I know I will be asked for my views. My choices will be respected when making decisions about my wellbeing. If my choices cannot be upheld, I will be provided with information that supports me to understand why. Te Tiriti: High-quality services are provided that are easy to access and navigate. Providers give clear and relevant messages so that individuals and whānau can effectively manage their own health, keep well, and live well. As service providers: We provide people using our services or their legal representatives with the information necessary to make informed decisions in accordance with their rights and their ability to exercise independence, choice, and control.	FA	There was an informed consent policy that was in line with the Code to ensure that a resident who had capacity/competence to consent to treatment or procedure had been given sufficient information to enable them to arrive at a reasoned and voluntary decision. Staff interview provided confirmation that additional guidance was provided for staff in the event a resident was unable to provide consent. Competence to provide informed consent wad determined by the general practitioner (GP). All resident records sampled had signed consents.
Subsection 1.8: I have the right to complain The people: I feel it is easy to make a complaint. When I complain I am taken seriously and receive a timely response. Te Tiriti: Māori and whānau are at the centre of the health and disability system, as active partners in improving the system and their care and support. As service providers: We have a fair, transparent, and equitable system in place to easily receive and resolve or escalate complaints in a manner that leads to quality improvement.	FA	The organisation had policy and process in place to manage complaints that was in line with Right 10 of the Code of Health and Disability Service Consumers Rights (the Code). The complaint process was made freely available throughout the facility. The FM outlined that support for Māori residents could be accessed through Te Whatu Ora Capital, Coast Hutt Valley should Māori residents require support to navigate the complaints process. Residents and whānau stated they were made aware of the complaints process on admission and knew how to access the hard copy form if required. Whānau acknowledged they knew they could also raise issues through the UCG website. There had been three complaints logged over the 2022/2023 period thus far. Interview with FM and review of the residents' records evidenced that the UCG complaints policy and process had been followed. Information

		was recorded that evidenced that the complainant had been informed of the outcome and was satisfied that it could be closed. There had been no complaints to the Health and Disability Commissioner since the last audit.
Subsection 2.1: Governance The people: I trust the people governing the service to have the knowledge, integrity, and ability to empower the communities they serve. Te Tiriti: Honouring Te Tiriti, Māori participate in governance in partnership, experiencing meaningful inclusion on all governance bodies and having substantive input into organisational operational policies. As service providers: Our governance body is accountable for delivering a highquality service that is responsive, inclusive, and sensitive to the cultural diversity of communities we serve.	FA	Ultimate Care Churtonleigh is part of the UCG which is a registered New Zealand company with the executive team providing direction to the service. There is governance structure in place that monitors compliance with legislative, contractual, and regulatory requirements. The annual strategic, business plan, had key outcomes which were resident centred, such as resident satisfaction, health and safety, complaints, education, and fiscal stability. These were monitored at board meetings. The national relationships manager (NRM) advised that the core competencies that executive team are required to demonstrate included understanding the organisation's obligations under Te Tiriti o Waitangi, health equity, and cultural safety. Review of resident and whānau survey results evidenced that the organisation valued and prioritised input into service delivery from people receiving care. The UCG executive management team had a clinical governance structure in place that was appropriate to the size and complexity of the organisation. The clinical operations group (COG) reported to the board monthly on key aspects of service delivery. The Māori Health Plan described how the organisation would ensure they continued to focus on reducing barriers to equitable service delivery with priorities in place to build trusting relationships, engage residents and whānau in care delivery and continue to develop and strengthen the education programme in relation to cultural safety. The provider is certified to provide care for up to 36 residents requiring hospital (geriatric and medical), and rest home, level care with 34 beds being dual purpose. At time of audit there were 31 residents,16 of which were receiving rest home level care, and 15 who were receiving hospital level care. This was inclusive of one young person under 65 (physical) resident receiving hospital services under a Ministry of Health (MoH) contract.

Subsection 2.2: Quality and risk The people: I trust there are systems in place that keep me safe, are responsive, and are focused on improving my experience and outcomes of care. Te Tiriti: Service providers allocate appropriate resources to specifically address continuous quality improvement with a focus on achieving Māori health equity. As service providers: We have effective and organisation-wide governance systems in place relating to continuous quality improvement that take a risk-based approach, and these systems meet the needs of people using the services and our health care and support workers.	FA	The executive team reviewed and approved the quality and risk management plan annually. The plan outlined the identified internal and external organisational risks and the quality framework utilised to promote continuous quality improvement. There was an implemented annual schedule of internal audits. Areas of non-compliance included the implementation of a corrective action plan with sign off by the FM when completed. Identified trends were monitored and raised for discussion within the quality meetings. A reporting tool called the manager's reflective report captured a broad range of clinical information across all facilities. The organisation followed the UCG National Adverse Event Reporting policy for internal and external reporting. Section 31 notifications were sent to HealthCERT weekly whilst the current registered nurse (RN) staffing shortage continues (see 2.3.1), and for wounds/pressure injuries as required. A Section 31 notification was confirmed as being completed for the appointment of the FM three months ago. Review of documentation including staff meeting minutes and discussion with the clinical services manager (CSM) evidenced that the corrective actions were documented and evaluated prior to sign off with staff informed of the evaluations and outcomes. The previous finding is now closed (criterion 1.2.3.8 in the 2008 standards).
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 Moderate	Ultimate Care Churtonleigh staffing policy included the rationale for staff rostering and skill mix. This included a facility managers' roster allocation tool to ensure staffing levels were maintained at a safe level. However, at the time of the audit there was a significant national health workforce shortage. High staff turnover and a difficulty to recruit new RNs exacerbated the staffing gaps. Interviews with staff, residents, and whānau, plus review of the facility roster evidenced that not all shifts were covered by a RN. Level four senior care givers who have completed additional training in health and safety, assessment and emergency management provide the shift lead role in the absence of an RN. The FM worked 40 hours per week and was available after hours for operational issues. The clinical services manager (CSM) worked 40 hours

		per week and participated in a shared-on call roster providing after hours clinical support. Laundry and cleaning staff were rostered for part time hours seven days per week with hours rostered having been increased since the last audit. Staffing levels on the morning shift comprise of one RN or senior care giver (shift lead), and four care givers, the afternoon shift one RN or shift lead, and the night shift one RN or shift lead and one care giver. Review of the current and previous rosters evidenced that each week on average there was 15 shifts without an RN. Staff records sampled evidenced that staff had completed the competencies for their role. There was an implemented annual training programme relevant to the needs of the residents. The FM and CSM worked in tandem for recording the ongoing learning and development of staff. The organisation ensured the provision of opportunities for ongoing development for health care and support workers. Staff confirmed they were supported to upskill and maintain competency and felt valued as employees. Two RNs had completed InterRAI training. The organisation had implemented systems that ensured the accurate collection and sharing of Māori health information. The UCG cultural safety policy outlines that on admission each resident's ethnicity and specific cultural beliefs/values shall be documented in their individual care plan. Care plans sampled evidenced this was completed. The previous identified area for improvement relating to i) service provider availability remains open (1.2.8.1 in the 2008 standard). Part ii) of the previous identified area for improvement is now closed.
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	FA	Human resource management practices followed policies and processes which adhered to the principles of good employment practice and the Employment Relations Act 2000. Review of staff records confirmed the organisation's policy was consistently implemented and records were maintained. Recruitment processes included police vetting, and reference checks, with the FM taking responsibility for validating prospective staff members qualifications as well as the annual checks required. The UCG orientation policy outlines that all new staff are to complete an orientation which includes information specific to the organisation and the facility. Additional learning requirements are set out for each designation.

clinically and culturally safe, respectful, quality care and services.		New staff were buddied with an experienced staff member for a designated time which can be extended if required. Staff stated they had received an orientation that was appropriate to their role with a review of staff records providing evidence this was completed. Records sampled and discussion with the FM confirmed that information held about staff was accurate, relevant, and kept in a secure location with confidentiality maintained. There was an implemented system that ensured all staff had an opportunity to discuss and review their performance at defined intervals. Records evidenced that performance reviews were current with staff interviews providing further evidence that reviews were occurring at defined intervals.
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	Resident care plans are developed using an electronic system. Registered nurses are responsible for all residents' assessments, care planning and evaluation of care. Initial care plans are developed with the residents/next of kin/whānau, EPOA consent. They are based on data collected during the initial nursing assessments and on information from pre-entry assessments completed by the needs assessment service co-ordination (NASC) or other referral agencies. The assessments include information about, but not limited to, the resident's medical history, pain, nutrition, mobility, and skin condition. Assessments reviewed had been completed in consultation with the resident and whānau. Residents interviewed confirmed assessments were completed according to their needs and in the privacy of their bedrooms. The residents' cultural, spiritual and activities assessments are completed by the diversional therapist (DT) in conjunction with the RN. Information on residents' cultural needs, previous life experiences, interests, whānau, and spiritual needs is gathered during interview with the resident and/or their whānau and documented. Assessments are used to develop the resident's individual pastoral and activity care plans. The residents' activity needs are reviewed six monthly at the same time as the care plans and are part of the formal six-monthly multidisciplinary review process. The individualised long term care plans (LTCPs) are developed with information gathered during the initial assessments and from the interRAI assessment. Documented interventions and early warning signs address

		the residents' assessed needs. Short term care plans are developed for acute problems, for example, infections or weight loss. A Māori health care plan was used for residents identifying as Māori. The care plan guided staff in gathering information and documenting the support required to meet the Māori resident's needs. The initial medical assessment is completed by the GP within the required timeframe following admission. Residents' reviews by the GP are also completed within required timeframes and if their health status changes. There is documented evidence of the exemption from monthly GP visits when the resident's condition is considered stable. The GP interviewed visits the facility weekly and as required. They stated that there is good communication with the service, that they are informed of concerns in a timely manner and that care is of a good standard. The provider has access to an after-hours service. A physiotherapist comes weekly and visits residents referred by the CSM or RNs. Staff interviewed and education records sighted confirmed that staff had completed cultural training. Staff interviewed discussed how they implemented the learnings of tikanga Māori into their practice and provided examples. Resident and whānau interviews and records confirmed that they are kept informed of any changes, for example, GP visits, changes in medication and incidents. Provision of care reflected in the care plan was consistent with, and contributed to, meeting the residents assessed needs, goals, and aspirations. Support was identified for whānau. Staff discussed service provision to include providing services free from stigma and those which promoted acceptance and inclusion. The nursing progress notes are recorded and maintained. Monthly observations such as weight and blood pressure are completed and up to date. Neurological observations are recorded following all unwitnessed falls. Policies and procedures are in place to ensure continuity of service delivery. Staff interviews confirmed they are familiar with the needs of all residents and that they have access to the supplies and products they require. There was evidence of wound care products available. A review of wound care plans evidenced wounds were assessed in a timely manner and reviewed at appropriate intervals. Photos and measurements are taken

		as required. Where wounds required additional specialist input, this was initiated. Resident care is evaluated on each shift and reported at handover and in the progress notes. If any change is noted, this is reported to the RN. Long term care plans are formally evaluated every six months in conjunction with the interRAI re-assessments and when there was a change in the resident's condition. Evaluations include the degree of achievement towards meeting desired goals and outcomes. Clinical records sampled demonstrated that reviews of resident care were ongoing. Short term care plans are reviewed daily and signed off when the problem is resolved. Handover meetings between each shift ensure residents progress towards meeting identified goals are discussed. Where progress is different from that expected, changes to the resident's care plan are made and actions implemented. This was verified in clinical files sampled and during staff and resident interviews. Ultimate Care Group has developed policies and procedures in conjunction with the other relevant services and organisations to support tāngata whaikaha. These services and organisations had representation from tāngata whaikaha.
Subsection 3.4: My medication The people: I receive my medication and blood products in a safe and timely manner. Te Tiriti: Service providers shall support and advocate for Māori to access appropriate medication and blood products. As service providers: We ensure people receive their medication and blood products in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	A current medication management policy identified all aspects of medicine management in line with relevant legislation, standards and guidelines. A safe system for medicine management using an electronic system was observed on the day of audit. The provider uses pharmacy pre-packaged medicines that are checked by an RN on delivery. Stock medication is available only for hospital level residents. Stock medications sighted were within current use by dates. A system is in place for returning expired or unwanted medication. The medication refrigerator and medication room temperatures are monitored as per UCG policy and were within the required range. The previous finding regarding monitoring and regulation of the medication room temperature is now closed (criterion 1.3.12.1 in the 2008 standards). Resident allergies and sensitivities are documented on the electronic medication chart and in the resident's electronic record. Controlled medications are stored securely in accordance with requirements. Controlled medications are checked by two staff for accuracy

		in administration. Weekly checks of medications and six monthly stocktakes are conducted in line with policy and legislation. Staff observed administering medication demonstrated clear understanding of their roles and responsibilities related to each stage of medication management and complied with the medicine administration policies and procedures. Registered nurses oversee the use of all 'as required' (PRN) medicines and documentation made regarding effectiveness was sighted. Current medication competencies were evident in staff files. No residents were self-administering medication. There were no standing orders in place.
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	A nutritional assessment is undertaken by a RN for each resident on admission to identify the residents' dietary requirements, allergies / sensitivities, and preferences. The nutritional profiles are communicated to kitchen staff and updated when a resident's dietary needs change. Diets are modified as needed and the cook confirmed awareness of the dietary needs, allergies/ sensitivities, likes and dislikes and dietary cultural needs of residents. These are accommodated in daily meal planning. The food service is provided in line with recognised nutritional guidelines for older people. The seasonal menu had been approved by a New Zealand registered dietician, with the winter menu implemented at the time of audit. The Food Control Plan expiry date is June 2024.
Subsection 3.6: Transition, transfer, and discharge The people: I work together with my service provider so they know what matters to me, and we can decide what best supports my wellbeing when I leave the service. Te Tiriti: Service providers advocate for Māori to ensure they and whānau receive the necessary support during their transition, transfer, and discharge. As service providers: We ensure the people using our service experience consistency and continuity when leaving our	FA	Records sampled evidenced that transition, exit, discharge, or transfer was managed with consultation with residents and whānau in a planned and coordinated manner and included information on current needs. The transfer/discharge documentation is generated by the electronic system and includes, but was not limited to, risk management information, a summary care plan and medication chart. The provider uses the 'yellow envelope' system for transfers to another service or facility.

services. We work alongside each person and whānau to provide and coordinate a supported transition of care or support.		
Subsection 4.1: The facility The people: I feel the environment is designed in a way that is safe and is sensitive to my needs. I am able to enter, exit, and move around the environment freely and safely. Te Tiriti: The environment and setting are designed to be Māori-centred and culturally safe for Māori and whānau. As service providers: Our physical environment is safe, well maintained, tidy, and comfortable and accessible, and the people we deliver services to can move independently and freely throughout. The physical environment optimises people's sense of belonging, independence, interaction, and function.	FA	A building warrant of fitness was current to October 2023. Buildings plant and equipment complied with legislation relevant to the health and disability service provided. Staff provided evidence that the calibration of equipment and electrical testing and tagging is completed, temperatures are recorded in resident areas with an action plan in place to address anomalies, and the preventative and reactive maintenance schedule is maintained. The internal and external physical environment was noted to be safe and accessible and promoted safe mobility and independence. Areas were available throughout the facility that enabled residents and their visitors to meet privately and partake in cultural activities if they wished. The previous identified areas for improvement relating to i) temperatures in resident areas had been above 45 degrees Celsius for all of 2021 and ii) exposed tree roots is now closed (criterion 1.4.2.4 in the 2008 standard).
Subsection 5.2: The infection prevention programme and implementation The people: I trust my provider is committed to implementing policies, systems, and processes to manage my risk of infection. Te Tiriti: The infection prevention programme is culturally safe. Communication about the programme is easy to access and navigate and messages are clear and relevant. As service providers: We develop and implement an infection prevention programme that is appropriate to the needs, size, and scope of our services.	FA	The infection control programme was appropriate for the size and complexity of the service. The infection prevention and control programme was reviewed annually and linked to the quality and business plan. The UCG clinical operations group (COG) involved staff at site level in the review of policies and procedures and the infection prevention and control nurse (IPCN) had input when IP policies and procedures were reviewed. The IPCN reports to the regional manager and the clinical coach. Audit outcomes are benchmarked against other UCG facilities, and this information is available to the facility staff and to the board. The CSM was the infection prevention and control nurse (IPCN) and had completed training for the role. The IPCN were responsible for coordinating/providing education and training to staff. The orientation package included specific training around hand hygiene and standard precautions. Annual infection control training was included in the mandatory

		in-services. Staff had completed infection control education in the last 12 months. The IPCN had access to an online training system with resources, guidelines, and best practice.
Subsection 5.4: Surveillance of health care-associated infection (HAI) The people: My health and progress are monitored as part of the surveillance programme. Te Tiriti: Surveillance is culturally safe and monitored by ethnicity. As service providers: We carry out surveillance of HAIs and multi-drug-resistant organisms in accordance with national and regional surveillance programmes, agreed objectives, priorities, and methods specified in the infection prevention programme, and with an equity focus.	PA Low	Surveillance was an integral part of the infection control programme. The surveillance undertaken was detailed in the infection prevention and control programme. This included monitoring positive results for infections and outbreaks. The purpose and methodology were described in the UCG surveillance policy. The CSM and the ICPN used the information obtained through surveillance to determine infection control activities, resources and education needs within the service. Monthly infection data was collected for all infections based on standard definitions, however not all required detail was included in the data collection or reporting. Infection control data was monitored and evaluated monthly and annually. Trends were identified and analysed, and corrective actions were established where trends were identified. These, along with outcomes and actions were discussed at the staff meetings. Meeting minutes were available to all staff. Variances in trends in surveillance data were identified and investigated as verified during interview. Staff were made aware of new infections at handovers on each shift, progress notes and clinical records. Short term care plans were developed to guide care for residents with an infection. There were processes in place to isolate infectious residents when required. Monthly surveillance data was collected and reported to the executive team. Trends, and opportunities to improve were considered by the IPCN and the national clinical services manager. There were no trends identified in IPC documents sampled.
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	FA	The provider promoted a restraint free environment. All restraint practice was managed through an established process consistently across all Ultimate Care Group facilities. Executive leaders received restraint reports monthly alongside aggregated restraint data, including the type and frequency of restraint if restraint had occurred. This formed part of regular

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.		reporting to the board. Records confirmed the completion of restraint minimisation and safe restraint use training with annual updates completed. Staff reported they were trained and considered competent to manage challenging behaviour. Staff records, documentation confirmed this. Staff interviewed, confirmed the processes that were required for Māori residents when considering restraint or if restraint practice was implemented. There were no residents using restraint during the audit.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 2.3.1 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 Moderate	Due to the effects of a national pandemic, global health workforce shortages, and staff turnover the provider does not meet the requirements of the aged residential care (ARRC) agreement with Te Whatu Ora for 24/7 RN cover. Risk mitigation in place includes, the FM, CSM, and a casual RN provide after-hours operational and clinical support, complex residents have been declined until the RN staffing levels have increased, laundry staff rostered additional hours to free up care staff to provide more dedicated time to resident care, and a recruitment process was underway for additional RN resource.	The provider is unable to provide 24/7 RN cover as per contractual obligations.	Ensure there is 24/7 RN cover as contractual obligations 180 days
Criterion 5.4.3 Surveillance methods, tools, documentation, analysis, and	PA Low	Surveillance reports documented the residents name, national health index (NHI) number and other relevant data, however the resident’s ethnicity was not included	Surveillance reports do not include the resident’s ethnicity.	Ensure surveillance reports include the

assignment of responsibilities shall be described and documented using standardised surveillance definitions. Surveillance includes ethnicity data.		on the report.		resident's ethnicity. 180 days

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.