

The Ultimate Care Group Limited - Ultimate Care Aroha

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 Manatū Hauora (the Ministry of Health).

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

You can view a full copy of the standard on the Manatū Hauora website by clicking [here](#).

The specifics of this audit included:

Legal entity:	The Ultimate Care Group Limited	
Premises audited:	Ultimate Care Aroha	
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: 7 December 2023	End date: 8 December 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:	40	

Executive summary of the audit

Introduction

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

- ō tātou motika | our rights
- hunga mahi me te hanganga | workforce and structure
- ngā huarahi ki te oranga | pathways to wellbeing
- te aro ki te tangata me te taiao haumarū | 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 Aroha is part of the Ultimate Care Group Limited. It is certified to provide care for up to 46 residents requiring rest home, hospital, or dementia care. Since the previous audit a new facility manager had been appointed.

Additionally, the organisation has made changes to the clinical governance structure since the previous audit.

This certification audit was conducted against the Ngā Paerewa Health and Disability services standard NZS8134:2021 and the service contracts with Te Whatu Ora Te Pae Hauora o Ruahine o Tararua MidCentral. The audit process included review of policies and procedures, review of resident and staff records, observations and interviews with staff, residents, whānau, a general practitioner and a kaumatua. Observations were made throughout the audit including the medication round, meal service, laundry services, and the activities programme.

Areas identified as requiring improvement relate to medication management, care planning and evaluation of anti-microbial data.

Ō tātou motika | Our rights

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

Subsections applicable to this service fully attained.

The service complies with Health and Disability Commission Code of Health and Disability Consumer's Rights (the Code). Residents receive services in a manner that considers their dignity, privacy, independence and facilitates their informed choice and consent. Care plans accommodate the choices of residents and/or their whānau.

Staff received training in Te Tiriti o Waitangi and cultural safety which was reflected in service delivery. Care was provided in a way that focused on the individual and considered values, beliefs, culture, religion, and relationship status.

Policies were implemented to support resident's rights, communication, complaints management, and protection from abuse. The service had a culture of open disclosure.

Hunga mahi me te hanganga | Workforce and structure

Includes five subsections that support an outcome where people receive quality services through effective governance and a supported workforce.

Subsections applicable to this service fully attained.

Ultimate Care Group is the governing body responsible for the services provided. The organisation's mission statement and vision were documented and displayed. The facility has current business and quality risk management plans.

The provider has appointed a new facility manager since the last audit. The facility manager ensures the management of the facility with the support of a clinical services manager. A regional manager supports the facility manager and provided additional support throughout this audit.

Quality and risk management systems were in place. Meetings were held that included reporting on various clinical indicators, quality and risk issues and there was review of identified trends.

There were human resource policies and procedures that guide practice in relation to recruitment, orientation, and management of staff. A systematic approach to identify and deliver ongoing training supports safe service delivery. There was sufficient number of staff on site at all times with provision of after-hours support for operational and clinical issues.

Systems were in place to ensure the secure management of resident and staff information.

Ngā huarahi ki te ora | Pathways to wellbeing

Includes eight subsections that support an outcome where people participate in the development of their pathway to wellbeing, and receive timely assessment, followed by services that are planned, coordinated, and delivered in a manner that is tailored to their needs.		Some subsections applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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There is a wholistic model of care utilised to ensure residents centred care was achieved. Information was provided to potential residents and family/whānau that ensured they were involved in decisions.

Resident assessments were completed and informed care plan development. Care plans were implemented with input from the resident and family/whānau which contributed to achieving the resident's goals. Clinical staff complete regular reviews of care plans. There was an activity programme facilitated to maintain resident's physical, social, and mental health needs.

Medicine management systems and processes were in place. Staff who administered medication had completed competency assessments. The discharge and/or transfer of residents was safely managed. The general practitioner interviewed stated the provision of care met the resident's needs.

Meal services are provided in line with the nutritional needs of the residents. Residents' preferences and allergies are known to staff and managed. Residents inform the meals and snacks available. The menu is approved by a registered dietician and there is a current food control plan.

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

Includes two subsections that support an outcome where Health and disability services are provided in a safe environment appropriate to the age and needs of the people receiving services that facilitates independence and meets the needs of people with disabilities.		Subsections applicable to this service fully attained.
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The organisation maintains a safe and appropriate environment. A reactive and preventative maintenance programme was implemented. External areas provide safe seating and shade. The garden area accessible for residents in the secure dementia wing had brightly coloured chairs and ensured safe access for residents to enjoy the gardens.

Resident rooms were of an appropriate size for the safe use and manoeuvring of mobility aids and provision of care. Lounge and dining areas provided spaces for residents and their visitors. Communal and individual spaces were maintained at a comfortable temperature.

A call bell system allowed for residents to access help when required. Security systems were in place and staff were trained in emergency procedures and use of emergency equipment/supplies. Alternative energy and utility sources were available in the event of the main supplies failing.

Emergency and security arrangements were outlined to all people using the services and/or entering the facility. There was a staff member with a current first aid certificate on duty at all times.

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

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

Some subsections applicable to this service partially attained and of low risk.

The safety of residents, staff and visitors is supported through the infection prevention programme. The infection prevention programme was appropriate for the size, complexity, and type of service. The antimicrobial stewardship programme is in the process of implementation. The clinical nurse manager is the infection prevention and microbial stewardship leader for the service and implements the programmes. There is a pandemic plan in place that is annually reviewed. Staff training included infection control and antimicrobial stewardship. A surveillance programme was implemented. Infection data was collected and collated. Cleaning and laundry processes are implemented in line with best practice infection prevention and waste management guidelines.

Here taratahi | Restraint and seclusion

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

Subsections applicable to this service fully attained.

The organisation has a restraint-free philosophy, and this is supported by the senior leadership team and board. Staff have access to restraint minimisation policies and procedures. A comprehensive assessment, approval, and monitoring process, with regular reviews, is accessed should restraint use be required. The clinical manager is the restraint coordinator and would manage the process should this occur. Staff discussed providing the least restrictive practice, de-escalation techniques, alternative interventions

to restraint, and restraint monitoring. De-escalation and restraint training is facilitated. There were no residents using restraint at the time of the audit.

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	24	0	1	2	0	0
Criteria	0	166	0	1	2	0	0

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

Attainment against the Ngā paerewa Health and disability services standard

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

For more information on the standard, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Subsection with desired outcome	Attainment Rating	Audit Evidence
<p>Subsection 1.1: Pae ora healthy futures</p> <p>Te Tiriti: Māori flourish and thrive in an environment that enables good health and wellbeing.</p> <p>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.</p>	FA	<p>Staff received training in cultural safety at orientation. The organisation had developed a cultural safety module that was provided as part of the annual education programme. It defines and explains cultural safety and its importance including Te Tiriti o Waitangi and tikanga best practice. Training records sampled evidenced that 85% of staff had completed training with a plan in place to follow up with staff who were yet to complete this.</p> <p>The organisation has a Māori health action plan that recognises the principles of Te Tiriti o Waitangi and describes how the Ultimate Care Group (UCG) responds to Māori cultural needs in relation to health and illness. The health plan outlines that the recruitment of Māori staff will be encouraged, and the facility manager (FM) outlined examples of how this was implemented. There were staff members employed who identified as Māori. The plan describes the aims of UCG to ensure outcomes for Māori are positive and equitable. Strategies include but are not limited to, identifying priority areas for leadership to focus upon and increasing the knowledge base across the organisation underpinned by Mātauranga Māori. The document outlines the importance of ensuring any resident who identified as Māori would have the opportunity to have whānau involved in their care. Documents were provided in te reo Māori.</p>

		The provider has established formal links with local Māori and an interview with a kaumatua outlined how this partnership transpires to resident care and staff learning and development.
<p>Subsection 1.2: Ola manuia of Pacific peoples in Aotearoa</p> <p>The people: Pacific peoples in Aotearoa are entitled to live and enjoy good health and wellbeing.</p> <p>Te Tiriti: Pacific peoples acknowledge the mana whenua of Aotearoa as tuakana and commit to supporting them to achieve tino rangatiratanga.</p> <p>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.</p>	FA	<p>The Pacific plan outlines the organisations commitment to providing culturally safe care. It defines 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. The plan outlines how the organisation will endeavour to achieve equity through partnerships with Pacific communities and collaboration. The regional manager (RM) was previously the FM for the facility and outlined the community connections in place with the local Pacific community.</p> <p>The organisation has developed a strategy that ensures a Pacific health and wellbeing workforce is recruited and retained across the organisation. The FM outlined how this was implemented.</p> <p>There were no residents who identified as Pacific at time of audit, however information gathered during the admission process includes identifying a resident's specific cultural needs, spiritual values and beliefs.</p>
<p>Subsection 1.3: My rights during service delivery</p> <p>The People: My rights have meaningful effect through the actions and behaviours of others.</p> <p>Te Tiriti: Service providers recognise Māori mana motuhake (self-determination).</p> <p>As service providers: We provide services and support to people in a way that upholds their rights and complies with legal requirements.</p>	FA	<p>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.</p> <p>Education records confirmed that staff had completed training which 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 the provision of care was provided in accordance with the Code. Residents and whānau were provided written information about the Code on admission and stated they were provided opportunities to discuss their rights. Further discussion evidenced they had been consulted about their care plan and were involved in decisions pertaining to their care. Māori residents and/or their whānau confirmed that they made independent decisions and whānau were involved as</p>

		<p>desired.</p> <p>Staff outlined they were aware of the advocacy service and how to support residents to contact the national advocacy service. Contact details were also available on posters throughout the facility. Interview with the facility advocate evidenced what support what was in place for the residents including attendance at resident meetings.</p> <p>Policy and practice include ensuring that all residents including any Māori residents right to self-determination was upheld and they can practise their own personal beliefs and values. The Māori health action plan identifies how UCG responds to Māori cultural needs in relation to health and illness.</p>
<p>Subsection 1.4: I am treated with respect</p> <p>The People: I can be who I am when I am treated with dignity and respect.</p> <p>Te Tiriti: Service providers commit to Māori mana motuhake.</p> <p>As service providers: We provide services and support to people in a way that is inclusive and respects their identity and their experiences.</p>	FA	<p>The provider ensured that residents and whānau were involved in planning and care which was inclusive of discussions and choices regarding maintaining independence. Resident, whānau and staff interviews plus observation confirmed that individual religions, social preferences, values, and beliefs were identified and upheld. These were also documented in resident records sampled.</p> <p>The provider had policies and procedures that were aligned to the requirements of the Privacy Act and Health Information Privacy Code to ensure that resident's right to privacy and dignity were upheld. Residents, whānau, and staff interview plus observation evidenced that staff knock on doors before entering, ensure doors are closed when personal cares were being provided, and confidentiality was maintained when staff were holding conversations that were personal in nature.</p> <p>Staff receive training in Te tiriti o Waitangi and tikanga best practice and have additional resources available to provide ongoing guidance. Staff were encouraged to use basic greetings and phrases in te reo Māori.</p> <p>The organisation supports tāngata whaikaha to do well with documentation outlining how staff will support with goal setting and achievement with all aspects of service delivery.</p>

<p>Subsection 1.5: I am protected from abuse</p> <p>The People: I feel safe and protected from abuse.</p> <p>Te Tiriti: Service providers provide culturally and clinically safe services for Māori, so they feel safe and are protected from abuse.</p> <p>As service providers: We ensure the people using our services are safe and protected from abuse.</p>	FA	<p>There was policy that includes 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 and whānau confirmed there was no evidence of abuse or neglect.</p> <p>The admission agreement signed prior to occupation provides clear expectations regarding management responsibilities of personal property and finances. Residents and/or their whānau provide consent for the administrator to manage the residents comfort funds. Discussion with the administrator and review of documentation evidenced that appropriate systems were in place that ensured the safe management of resident's comfort funds. Residents and/or their whānau provided further confirmation that resident property was respected.</p> <p>There were policies and procedures to ensure that the environment was free from discrimination, racism, coercion, harassment, and financial exploitation. They provide guidance to staff on how this was prevented, and where suspected, the reporting process.</p> <p>Staff were required to sign and abide by the UCG code of conduct and professional boundaries agreement. All staff records sampled evidenced these were signed. Staff mandatory training includes maintaining professional boundaries. Discussion with staff confirmed their understanding of professional boundaries relevant to their respective roles. Residents and/or whānau confirmed that professional boundaries were maintained.</p> <p>Residents described how they feel safe living in the facility with whānau providing further evidence that they feel comfortable to raise any issues and discussions were free and open.</p> <p>A review of documentation and interviews with staff evidenced that the organisation has prioritised the introduction of the Māori model of care te whare tapa wha across service delivery.</p>
<p>Subsection 1.6: Effective communication occurs</p>	FA	<p>There was policy to ensure that residents and their whānau have the right to comprehensive information supplied in a way that was</p>

<p>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.</p> <p>Te Tiriti: Services are easy to access and navigate and give clear and relevant health messages to Māori.</p> <p>As service providers: We listen and respect the voices of the people who use our services and effectively communicate with them about their choices.</p>		<p>appropriate and considered specific language requirements and disabilities. The FM confirmed that where required interpreters were accessed from Te Whatu Ora Te Pae Hauora o Ruahine MidCentral. At time of audit there were no residents who required an interpreter.</p> <p>Resident records sampled evidenced that other healthcare agencies were involved in resident care providing additional assessments and treatment regimens as required.</p> <p>There was policy which required whānau be advised within 24 hours of an adverse event occurring. Review of accident and incident information and staff and whānau interviews confirmed that timeframes were met, and open disclosure had occurred following an event involving a resident.</p> <p>Two monthly resident/whānau meetings inform residents and their whānau of facility activities. Meetings were advertised in the activities planner with reminders of what is coming up placed on notice boards throughout the facility. Meetings followed a set agenda and were chaired by the FM. Meeting minutes plus staff and resident interviews demonstrate attendance by residents and their whānau. The meeting minutes were taken by the resident advocate and capture issues raised, who is taking responsibility for follow up, the outcome of which is discussed, and the progress made. Resident meetings also offer an opportunity to provide feedback and make suggestions for improvement. Copies of the menu and activities plan were available to residents and their whānau.</p>
<p>Subsection 1.7: I am informed and able to make choices</p> <p>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.</p> <p>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.</p>	FA	<p>There was an informed consent policy and procedures that ensured consent processes aligned with the Code of Health and Disability Services Consumer's Rights (the Code). This ensured all residents 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 confirmed additional guidance was provided for staff in the event a resident is unable to provide consent. Competence to provide informed consent was determined by the general practitioner (GP).</p> <p>Staff received training on informed consent and informed choice during</p>

<p>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.</p>		<p>their orientation. All staff interviewed were cognisant of the procedures to uphold informed consent. The resident information pack included information regarding consent. The clinical services manager (CSM) or admitting registered nurse explains and discusses informed consent to residents and/or their whānau during the admission process to ensure understanding. This included consent for resuscitation and advanced directives. All resident records sampled had signatures for consent with enduring power of attorney (EPoA) signatures noted for those residents who were assessed as not being competent. Additional consents included student nurse participation and resident photos.</p> <p>The informed consent policy acknowledges Te Tiriti o Waitangi and the impact of culture and identity on the determinants of the health and wellbeing of Māori. It required health professionals to recognise these as relevant when issues of health care for Māori residents arises. The kaumatua confirmed that additional support could be provided for Māori residents if required throughout the consent process.</p>
<p>Subsection 1.8: I have the right to complain</p> <p>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.</p> <p>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.</p>	<p>FA</p>	<p>The organisation had a complaints process that aligned with consumer rights legislation. The process was confirmed to be transparent and equitable. The complaint process was made available in the admission agreement and explained by the admitting nurse. Complaint forms were easily accessed within the facility and UCG website enables complaints to be logged online. Interviews with the FM, staff, residents, and whānau confirmed that they were aware of the complaints process and were encouraged to raise any concerns and provide feedback. The kaumatua confirmed that support can be provided to assist Māori residents to navigate the complaints process.</p> <p>The FM is responsible for managing complaints. A complaints register was in place which included the name of the complainant, date the complaint was received, the date the complaint was responded to, and the date the complaint was closed. Evidence relating to the investigation of the complaint was included in the register including the date the complainant was informed of the outcome. An anonymous complaint received in 2022 regarding less-than-optimal staffing has been responded to appropriately and closed. All complaints received had been closed to the satisfaction of the complainant except for one which has</p>

		<p>only recently been received. Interview with the FM and review of the complaints received evidenced that the process was consistently followed.</p> <p>The FM advised there had been one complaint since the last audit that had health and disability advocate involvement which has now been closed.</p>
<p>Subsection 2.1: Governance</p> <p>The people: I trust the people governing the service to have the knowledge, integrity, and ability to empower the communities they serve.</p> <p>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.</p> <p>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.</p>	FA	<p>The Ultimate Care Aroha is part of Ultimate Care Group (UCG) which is a registered New Zealand company. There is a governance structure in place which monitors compliance with legislative, contractual, and regulatory requirements. There was Māori representation at governance level providing guidance to the organisation to ensure necessary actions were embedded across the organisation that enacts the principles of Te Tiriti o Waitangi. The national relationship manager has advised the core competencies executive management are required to demonstrate including understanding the organisations obligations under Te Tiriti o Waitangi, and cultural safety. It was reported that there have been no changes to the governing structure since the last audit. An executive team provides direction to the provider.</p> <p>The annual strategic business plan has key outcomes which are resident centred, such as resident satisfaction, health and safety, complaints, education, and fiscal stability. These were monitored at board meetings. Review of previous resident and whānau survey results evidenced that the organisation values and prioritises input into service delivery from people receiving care.</p> <p>The organisation has a documented strategy plan incorporating vision, mission, and values statements. The document was reviewed annually by the executive team and the board. The organisations values were displayed in the facility and were included within information available to residents and whānau.</p> <p>The Māori health action plan describes how the organisation was aware of barriers and inequities for Māori and how to reduce them. Staff are encouraged to learn and use basic Māori greetings/phrases and continue to upskill in Māori tikanga. Whānau are encouraged to have input into service improvement as confirmed by staff, residents and</p>

		<p>whānau and review of resident meeting minutes.</p> <p>The UCG management team has commenced a change to the clinical governance structure with the removal of regional clinical managers and the introduction of clinical coaches to provide clinical support to all UCG facilities. The clinical coaches provide support to ensure standards, policies, and procedures are met in the management of nursing care. However, this change is in its infancy and reporting lines and overall accountabilities for all clinical outcomes was yet to be clarified (See 3.2.3). The clinical manager (CM) confirmed that support was readily available by phone or face to face.</p> <p>The FM has a background in diversional therapy and has been in the role three months. The FM was the activities coordinator for the facility prior to being appointed. The FM reports to the regional manager (RM) who oversees the facility's quality and operational performance. The CM was appropriately qualified for the role with a background in aged care. The RM holds weekly video meetings with all facility/nurse managers and maintains face to face contact. The clinical coach for the region provides clinical support.</p> <p>The organisation has implemented robust systems to support the quality and risk management structure with a wide range of information gathered to inform service delivery. The executive team provides the necessary resources keeping staff informed and providing support as evidenced by staff interviews.</p> <p>The Māori health action plan outlines the organisations commitment to improving outcomes for tāngata whaikaha with the goals and actions required and the support required to achieve aspirations and reduce barriers. The organisation continues to focus on the need to prioritise the building of partnerships with Māori disability stakeholders.</p> <p>The provider is certified to provide rest home, hospital and dementia level care for up to 46 residents. Occupancy on day of audit comprised of 10 residents assessed as requiring rest home level care, 13 residents assessed as requiring dementia care and 17 residents assessed as requiring hospital level care. This was inclusive of one resident under 65 years requiring dementia care.</p>
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<p>Subsection 2.2: Quality and risk</p> <p>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.</p> <p>Te Tiriti: Service providers allocate appropriate resources to specifically address continuous quality improvement with a focus on achieving Māori health equity.</p> <p>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.</p>	FA	<p>The organisation has an annually reviewed, executive team approved, quality and risk management plan. The plan outlines the identified internal and external organisational risks and the quality framework utilised to promote continuous quality improvement. There were policies, and procedures and associated systems to ensure that the organisation meets accepted good practice and adheres to relevant standards relating to the Health and Disability Services (Safety) Act 2001.</p> <p>There was an implemented annual schedule of internal audits. Areas of non-compliance including the implementation of a corrective action plan included sign off by the FM or CM when completed. A reporting tool captures a broad range of information across all facilities.</p> <p>The CM takes overall responsibility for health and safety within the facility. The provider has made a commitment to ensuring all staff were aware of the importance of health and safety and incorporate additional staff training to the training schedule.</p> <p>The provider holds a comprehensive schedule for staff meetings that includes but is not limited to quality, health and safety, and staff with a high staff attendance evident in meeting records reviewed. Meetings follow a set agenda with a broad range of topics discussed. At interview, and review of resident meeting minutes it was noted that residents were involved in decision making/choices.</p> <p>The organisation follows the UCG adverse event reporting policy for external and internal reporting. Incident and accident events reviewed evidenced that staff had completed these in a timely manner, next of kin had been notified of events involving their family member and events had been fully investigated. However not all events involving medication events had followed the UCG process (See 3.4.1). Completed section 31 notifications were completed for the appointment of the FM, a resident absconding and for previous occasions when the provider was unable to</p>

		<p>provide RN cover as per contractual obligations.</p> <p>The organisation's commitment to providing high quality health care for Māori was stated within the Māori health action plan and policy. This included the provision of appropriate education for staff, supporting leaders to champion high quality health care and ensuring that resident centred values guide clinical decision making. The organisations progress in these domains was analysed at executive and board level and improvements made when progress was less than optimal.</p>
<p>Subsection 2.3: Service management</p> <p>The people: Skilled, caring health care and support workers listen to me, provide personalised care, and treat me as a whole person.</p> <p>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.</p> <p>As service providers: We ensure our day-to-day operation is managed to deliver effective person-centred and whānau-centred services.</p>	FA	<p>The organisations staffing policy includes the rationale for staff rostering and skill mix inclusive of a facility managers roster allocation to ensure staffing was maintained at a safe level. Review of rosters evidenced that unplanned absences were covered appropriately by casual staff. The FM and CSM provided after hours support.</p> <p>The FM and CSM worked 40 hours per week. The morning shift comprised of one RN across the whole facility and two caregivers rostered in the rest home, two in the hospital and two in the dementia unit. The afternoon shift mirrored the morning roster with the addition of one caregiver rostered to cover the meal service. There was one RN and two caregivers rostered across the facility during the night. Nonclinical staff included household and laundry personnel, part time maintenance person and kitchen staff. Laundry and cleaning staff were rostered seven days per week. Interviews with residents and whānau advised they have not become aware of any staffing issues impacting on the residents or care delivery. Previous staffing difficulties have been addressed because of a successful recruitment campaign. There are currently five RNs employed across the service.</p> <p>There was an implemented annual training programme. Staff competencies, training and education scheduled were relevant to the needs of aged care residents. The attendance records were sighted with the FM and CSM taking responsibility for ensuring all staff attend training as required. Current cultural safety training schedule provides staff with the resources to support their practice and achieve equitable health outcomes. Four registered nurses (RNs) have completed InterRAI training with one due to complete this shortly.</p>

		<p>The provider collects both staff and resident ethnicity information data via the online platform and forms part of the monthly report compiled for the board. Support systems promote staff wellbeing, and a positive work environment was confirmed by staff. Employee support services were available when required.</p>
<p>Subsection 2.4: Health care and support workers</p> <p>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.</p> <p>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.</p> <p>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.</p>	FA	<p>The human resource management system follows policies and procedures which adheres to the principles of good employment practice and the Employment Relations Act 2000. Review of staff records confirmed the organisation's policy was consistently followed and records maintained. The recruitment process includes police vetting, reference checks, and validation of annual practising certificates/qualifications. Current practicing certificates were sighted for those staff and contractors that required these. Job descriptions include accountabilities/responsibilities specific to the role with a clear outline of who they report to. Personnel involved in driving the van used for resident outings held current drivers' licences and first aid certificates.</p> <p>There was a documented and implemented orientation programme and staff records evidenced that orientation was completed. Orientation covered the essential components of service delivery with specifics relating to their roles included. Staff confirmed completing this and advised that it was appropriate to their role. The provider rarely uses external agency staff however a separate policy and plan for their orientation was in place if required. Staff records sampled evidenced that staff had completed annual performance reviews, and documentation was complete and current.</p> <p>Information held about health care and support workers was kept in a secure location with confidentiality maintained. Staff interview and review of documentation evidenced that staff ethnicity data was collected, and review of staff records provided additional evidence that this was in place.</p> <p>The RM confirmed that opportunities were provided for staff in the event a debrief process was required and can provide additional support following significant events.</p>

<p>Subsection 2.5: Information</p> <p>The people: Service providers manage my information sensitively and in accordance with my wishes.</p> <p>Te Tiriti: Service providers collect, store, and use quality ethnicity data in order to achieve Māori health equity.</p> <p>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.</p>	<p>FA</p>	<p>Resident's records and medication charts were managed electronically. Residents' information including progress notes was entered into the residents' records in an accurate and timely manner. The name and designation of the author was identifiable. Residents' notes were completed every shift.</p> <p>There were policies and procedures in place to ensure the privacy and confidentiality of resident information. Staff confirmed awareness of their obligation to maintain confidentiality of all resident information. Resident care and support information can be accessed in a timely manner and was protected from unauthorised access.</p> <p>Records include information obtained on admission and information supplied from resident's whānau where applicable. The clinical records were integrated, including information such as medical notes, assessment information, and reports from other health professionals.</p> <p>The provider gathers information on admission regarding a resident's ethnicity which is reported though to UCG head office.</p> <p>The provider was not required to gather data regarding the national health index (NHI)</p>
<p>Subsection 3.1: Entry and declining entry</p> <p>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.</p> <p>Te Tiriti: Service providers work proactively to eliminate inequities between Māori and non-Māori by ensuring fair access to quality care.</p> <p>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.</p>	<p>FA</p>	<p>A website is maintained that provides current information about the Ultimate Care Group services available within the Manawatu area including how to access the facility.</p> <p>On admission residents and their whānau are provided written and verbal information with any questions raised answered by staff. Admission packs sighted provided comprehensive information. The information is available in multiple languages, written in plain language and citing key messages. Interpreters are available and used as required to ensure resident understanding is achieved. Staff interviewed reported they could access interpreter services if required.</p> <p>There were documented entry policies and processes in place and staff interviewed were able to discuss these in detail. Clinical records sampled, and residents interviewed, confirmed that entry requirements</p>

		<p>were met. Information (including ethnicity data) relating to admission, discharge and decline rates are analysed via a monthly report.</p> <p>Residents and whānau interviewed reported they were treated with respect throughout the admission process and understood the rationale for information required during the process, for example Enduring Power of Attorney (EPOA) status. They also confirmed that any questions raised were answered by staff in relation to admission, including waiting times.</p> <p>Staff interviewed confirmed the process that is undertaken when services are declined including communication with the referrer/family/whānau, alongside documentation required. In situations where the residents care requirements are outside the scope of the provider referral to other health/disability providers is completed. The GP confirmed in interview the referral pathways commonly used and these included secondary and primary health services in Palmerston North. Transfers occur in collaboration with the needs assessment and service coordination service (NASC) in Palmerston North.</p> <p>The provider has established relationships with the iwi of the region including local marae, Māori health providers, organisations, individuals, and communities to ensure appropriate support for tāngata whenua.</p>
<p>Subsection 3.2: My pathway to wellbeing</p> <p>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.</p> <p>Te Tiriti: Service providers work in partnership with Māori and whānau, and support their aspirations, mana motuhake, and whānau rangatiratanga.</p> <p>As service providers: We work in partnership with people and whānau to support wellbeing.</p>	<p>PA Moderate</p>	<p>Documented residents' assessments were completed on admission by a registered nurse and a medical practitioner. The assessments included the resident's history, pain, nutrition, mobility, skin condition, early warning signs (EWS), cultural needs and spiritual wellbeing, and documentation of the resident's life experience. The assessments sampled had been completed in consultation with the resident and whānau. The progress notes sampled; documented discussions were held with the residents around their care. Consent documents were documented in clinical files sampled.</p> <p>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. Observations on site confirmed Māori residents and whānau felt comfortable with tikanga upheld and involvement with the</p>

		<p>local marae in the day-to-day facility operations. There were staff who identified as Māori at the time of the audit who confirmed they could use te reo Māori.</p> <p>The electronic clinical files sampled were integrated and included documentation from all members of the multi-disciplinary team (MDT). Completed assessments were also contained in the clinical file. Resident and whānau interviews confirmed MDT meetings for reviews were undertaken with the residents, family/whānau and EPOA. The provision of care reflected in the care plan is consistent with, and contributes to, meeting the residents assessed needs, goals, and aspirations. Support is identified for whānau, and those interviewed confirmed they felt supported. They positively reported on the homely nature and inclusive aspects of support provided by staff. Staff discussed service provision to include providing services free from stigma and those which promote acceptance and inclusion.</p> <p>Risk assessments were completed by staff, and this is an ongoing process. Any changes in the resident's condition are documented and where needed acted upon. Clinical escalation processes were discussed. There has been an organisational restructure mid-year 2023. The regional clinical managers roles have been removed and clinical coaches introduced. The clinical manager onsite receives practice support from the clinical coach. The clinical coach is able to provide a range of practice supports intended for the whole facility. The clinical manager reported this has provided clinical assistance whilst three experienced RNs were currently on maternity leave. The restructure allows for new reporting lines from the clinical manager to the organisation's clinical lead. Clinical staff interviewed were unclear about their reporting lines at the time of the audit. Clinical records sampled confirmed that when escalation was required, this had occurred clinically and was documented. For example, after a fall with injury. It was confirmed onsite that not all incidents/events although documented, were reported through the new reporting lines to ensure the appropriate people and roles were informed. It was also confirmed at the time of the audit that clinical indicators were raised in the facility and that onsite staff had not yet made a facility wide clinical plan to respond the increasing numbers of falls, wounds, and infections (refer finding 3.2.3)</p> <p>The clinical records sampled demonstrated that reviews of resident care</p>
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		<p>were ongoing with MDT meetings completed a least six monthly. All reviews were completed by registered health professionals including doctors, nurses, and physiotherapists. Handover meetings between each shift ensure residents progress towards meeting identified goals was considered. Where progress was different from that expected, changes to the resident's care plan were made and actions implemented. This was verified in clinical files sampled and during staff and resident interviews. Short term care plans were in place as needed.</p> <p>The organisation 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. Interviews with staff confirmed that staff were able to facilitate tāngata whaikaha access to information should this be required.</p> <p>Staff discussed their understanding of support required for Māori and whānau to identify their own pae ora outcomes in their care or support plan, how these could be achieved and documented if required. A Māori resident and whānau confirmed they were able to do this.</p>
<p>Subsection 3.3: Individualised activities</p> <p>The people: I participate in what matters to me in a way that I like.</p> <p>Te Tiriti: Service providers support Māori community initiatives and activities that promote whanaungatanga.</p> <p>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.</p>	FA	<p>There are two lounges available for residents both with a television, and a variety of activities for use including books, cards, and jigsaws. There is an activities coordinator (AC) employed for Monday to Saturday overseen by the facility manager who is a trained diversional therapist. There are also activities administration support for updating and evaluating plans maintained electronically. Care staff support residents' activity needs on Sunday. A trained volunteer is engaged to support regular Tuesday outings into the community.</p> <p>The monthly activities plan was reviewed and included a variety of physical, intellectual, and pleasurable activities for groups and individuals. One on one time is provided and includes hand massages, card making and reading. There is a budget for activities and confirmed this provides opportunity for a variety of experiences including weekly outings, and resources such as board games. The audit team observed two separate musical groups entertaining the residents on both days of the audit. The residents engaged positively and were prompted to sing and dance as they desired. Families/whānau are encouraged to join in</p>

		<p>where possible. Activities plans sampled for Dementia residents reflected their 24 hour a day requirements.</p> <p>Clinical files sampled across all services evidenced that the residents' strengths, skills, and interests had been assessed and were considered when planning care. A whole team approach was engaged to support the resident's care. The audit team observed a happy environment with positive engagement between residents, whānau and staff. Information was displayed for residents and family/whānau related to service aligned community groups in communal spaces and in each bedroom. Staff discussed residents leave where this was possible and how this was facilitated and supported. Families/ whānau are encouraged to visit and spend time doing activities in the gardens outside or in quiet spaces.</p> <p>Staff interviewed confirmed that they had been enabled to complete Māori cultural awareness education. The provider is very involved with the local marae and have frequent visits from marae members. Whānau interviewed reported they were made aware of community activities that supported the cultural needs of their loved ones. Senior staff interviewed onsite confirmed the involvement of Māori and communities in the delivery of services is encouraged and reflected the strategic documents in place.</p> <p>On admission the nursing staff discuss with the resident their cultural requirements, and these are documented. Individual files sampled confirmed these were completed in detail.</p>
<p>Subsection 3.4: My medication</p> <p>The people: I receive my medication and blood products in a safe and timely manner.</p> <p>Te Tiriti: Service providers shall support and advocate for Māori to access appropriate medication and blood products.</p> <p>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.</p>	<p>PA Moderate</p>	<p>A current medication management policy identifies all aspects of medicine management in line with relevant legislation, standards and guidelines. The electronic medicine management system was observed on the day of audit. Prescribing practices are in line with legislation. The required three-monthly reviews by the GP were recorded electronically. Resident allergies and sensitivities are documented on the electronic medication chart and the resident's record.</p> <p>There is one medication room onsite situated in the hospital wing. Two trolleys are set up and provide opportunity for efficient medication administration. The provider uses pharmacy pre-packaged medicines that are checked by the RN on delivery two weekly. A system is in place</p>

		<p>for returning expired or unwanted medication to the contracted pharmacy. Out of ordinary medicines prescribed can be delivered on the same day. Weekly checks of medications and six monthly stocktakes are conducted in line with policy and legislation. The last pharmacy check was conducted in June 2023. The medication refrigerator temperature and medication room temperature are monitored as per UCG policy and are within the required range. The medication room was recorded at 18.8 degrees Celsius on the first day of the audit.</p> <p>Medications are stored securely in accordance with requirements. Medications are checked by staff who have completed the medication competency. There are five RNs and five medication competent health care assistants (HCAs) who administer medication. Staff observed administering medication demonstrated knowledge and at interview demonstrated clear understanding of their roles and responsibilities related to each stage of medication management and complied with the medicine administration policies and procedures. Current medication competencies were evident in staff files. Education for residents regarding medications occurs on a one-to-one basis by the GP, or RN.</p> <p>Controlled medication is checked by two competent staff. There is a system in place for “as required” (PRN) medication and staff interviewed confirmed this. In all medication files sampled, all PRN medication documentation was appropriately documented to include indications for use and medication effectiveness.</p> <p>There were no residents self-administering medication at the time of the audit and no standing orders in place. There is a policy and procedure available to staff should a resident wish to self-medicate which includes approval by the GP. Additional information provides guidance for staff in the event standing orders were used. The UCG medication policy describes use of over-the-counter medications and traditional Māori medications and the requirement for these to be discussed with, and/or prescribed by, a medical practitioner. Interview with the GP, CM and RN confirmed that where over the counter or alternative medications were being used, they were added to the medication chart following discussion with the resident and/or their family/whānau.</p> <p>At the time of the audit, it was noted that medication errors had occurred in recent months and that not all errors had been managed as required</p>
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		(refer finding 3.4.1).
<p>Subsection 3.5: Nutrition to support wellbeing</p> <p>The people: Service providers meet my nutritional needs and consider my food preferences.</p> <p>Te Tiriti: Menu development respects and supports cultural beliefs, values, and protocols around food and access to traditional foods.</p> <p>As service providers: We ensure people's nutrition and hydration needs are met to promote and maintain their health and wellbeing.</p>	FA	<p>The organisation has a New Zealand Registered Dietitian who informs and signs off on the organisation's meal plans. There was a meal plan in place which reflected the season. The current Food Control Plan expires 27 June 2024.</p> <p>There are two chefs employed who provide kitchen services seven days a week and both were interviewed. Meals were prepared on-site. Staff reported their dedication to ensuring they consistently provided restaurant quality food. Residents had informed the service providing feedback through a resident food survey. The results had identified that residents wanted a restaurant dining experience. New plates and glasses were purchased, and table settings have changed to reflect a restaurant. Residents interviewed confirmed their satisfaction with the meal service provided. Family/whānau interviews confirmed a high level of satisfaction with the food service provided including meals and snacks for families as desired. Residents are supported to be involved with food preparation with the example given when the provider celebrated Matariki. Home baking is available twice daily. The two meal services observed confirmed a pleasant restaurant experience was achieved with music and, residents and relatives reported meals were of a high-quality. Dementia residents have snacks and beverages available throughout the day and night.</p> <p>Meat is delivered daily, vegetables every second day, frozen foods stored separately and sufficient stores available for more than three days if required in an emergency. A BBQ is available if required.</p> <p>As part of the assessment process when residents are admitted, staff identify any allergies/sensitivities/ special diets/ likes and/or dislikes and these are provided to the kitchen staff on the same day of admission. Special diets were discussed in staff interview and confirmed as appropriate and responsive to resident preferences. Observation of the kitchen confirmed clean neat orderly areas with resident sensitivities listed on the kitchen wall. Soft options and special foods are kept separately in labelled fridges. Staff confirmed they were aware of resident allergies/sensitivities and those residents requiring special</p>

		<p>foods. There were three dining areas, the main lounge and dining room, dementia unit with dining area and hospital lounge/dining. Staff were observed assisting with meals and this was done sensitively and carefully.</p> <p>There was one kitchen on site and a small kitchenette in the hospital wing. The main kitchen provides food for the whole facility. Food is transported safely to the hospital lounge and Dementia unit in a food trolley. Food temperatures are recorded, and documentation maintained. All food temperature documentation sighted confirmed food was managed safely at required temperatures. Fridge and freezer temperatures were monitored.</p> <p>There are opportunities for Māori residents to request special diets and this was confirmed in staff, resident, and whānau interviews.</p>
<p>Subsection 3.6: Transition, transfer, and discharge</p> <p>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.</p> <p>Te Tiriti: Service providers advocate for Māori to ensure they and whānau receive the necessary support during their transition, transfer, and discharge.</p> <p>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.</p>	FA	<p>There are policies and processes that guided the transition, transfer, and discharge of residents. Staff interviewed were aware of the procedures required and discussed these during the audit. Documentation reviewed evidenced that transition, transfer, and discharge was planned and in response to the resident's health and well-being and this was confirmed during staff interviews. The clinical files sampled, and staff interviews confirmed that the discharge process was undertaken in a timely manner.</p> <p>Staff interviewed were able to discuss other health and disability services and/or social support agencies that were suitable for the residents should that be indicated. Brochures were displayed in the facility that provided information about a range of community health and social support agencies.</p> <p>Individualised discharge plans are discussed at MDT meetings as required or at least six monthly. Interviews and clinical files sampled documented that the required assessments and interventions had been completed to meet any discharge planning goals and mitigate risks associated with transfer/discharge.</p> <p>Where needed staff can identify kaupapa Māori services as options for residents when transfers/discharges are considered for Māori residents.</p>

		Staff confirmed their relationships with kaupapa Māori services, and these had been utilised in the past.
<p>Subsection 4.1: The facility</p> <p>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.</p> <p>Te Tiriti: The environment and setting are designed to be Māori-centred and culturally safe for Māori and whānau.</p> <p>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.</p>	FA	<p>The building warrant of fitness was current to August 2024. Buildings plant and equipment complied with the legislation relevant to the service being provided. A preventative and reactive maintenance schedule was implemented. This included monthly checks of all areas and specific equipment such as hoists. Staff identified maintenance issues via an electronic system. This information was reviewed by the maintenance person and prioritised. Staff confirmed awareness of the process for maintenance requests and confirmed repairs were conducted in a timely manner. The maintenance person outlined they work in tandem with the FM to ensure hazards were identified, documented in the hazard register, and reviewed. The FM maintains responsibility for ensuring the register was current.</p> <p>Interviews with staff and visual inspection confirmed there was adequate equipment to support care. The facility had an up-to-date electrical testing and tagging programme. There was a system in place to ensure the facility van was routinely maintained and the warrant of fitness and vehicle registration remained current. All staff who drive the van are required to have a driver's licence with no previous driving convictions and a first aid certificate. The maintenance person outlined that the facility required all van drivers to complete a safety check for the safe entry and exit for residents to the van which was overseen by a physiotherapist.</p> <p>The maintenance person confirmed that a system was in place that ensured all hot water temperatures were regularly checked and all anomalies were addressed as soon as possible. The FM was notified as required.</p> <p>All areas can be accessed with mobility aids. There were accessible external areas for residents and their visitors that provided shade and seating. Entry to the secure dementia unit was by entering a code to the keypad only. The courtyard accessible for residents within the secure dementia wing had brightly coloured chairs and safe pathways enabling residents to enjoy the garden. There were sufficient toilets facilities</p>

		<p>available for residents and visitors. All communal toilets had a system to indicate vacancy and provided disability access. All showers and toilet facilities had call bells, sufficient room, approved handrails, and other equipment to facilitate ease of mobility and promote safety and independence.</p> <p>Residents have their own room, and each is of sufficient size to allow residents to mobilise safely around their personal space and bed area with mobility aids and/or assistance. Observations and interviews evidenced that space for hoists, wheelchairs, and walking frames was adequate.</p> <p>All resident rooms and communal areas accessed by residents were ventilated with at least one external window providing natural light. Resident rooms were heated in winter and cooled in summer. This was confirmed by staff, residents and whānau. The environment in resident areas was noted to be maintained at a satisfactory temperature.</p> <p>The kaumatua confirmed that in the event of additions to the facility Māori consultation would be available via established links within the community.</p>
<p>Subsection 4.2: Security of people and workforce</p> <p>The people: I trust that if there is an emergency, my service provider will ensure I am safe.</p> <p>Te Tiriti: Service providers provide quality information on emergency and security arrangements to Māori and whānau.</p> <p>As service providers: We deliver care and support in a planned and safe way, including during an emergency or unexpected event.</p>	FA	<p>There was a suite of policies and procedures related to the management of emergencies. Staff confirmed they were familiar with these and described their role in the event of an emergency. Induction of new staff included training in fire and emergency procedures and staff records sampled confirmed this had been completed. Fire drills and emergency evacuations were completed at least six monthly with the last one completed one month prior to the audit. Emergency exit doors were sign posted throughout the facility. These were noted to be free from obstruction.</p> <p>The evacuation plan had been approved by Fire and Emergency New Zealand (FENZ). Fire extinguishers were strategically placed throughout the facility and had been checked within the last 12 months by a contracted service.</p> <p>Residents and whānau were advised of the facility's emergency responses on admission. The RM explained the expected emergency</p>

		<p>response to the audit team at the beginning of the audit process. Emergency flip charts and floor plans were located at prominent locations in each wing. Each shift had at least one staff member with a current first aid certificate. This was confirmed by education records and staff rosters.</p> <p>Battery lighting was utilised in the event of a power failure, with multiple torches on hand to provide additional lighting. In the event of a prolonged power outage the facility had a contract with a service that ensured the facility had priority accessing a generator. The supply of emergency food and water was noted to be sufficient for a minimum of three days.</p> <p>There was a call bell in each resident's bedroom, and all bathrooms. Other call bells were strategically placed throughout the facility. A security alarm has been installed in the facility as well as closed circuit television cameras. Senior staff were responsible to complete a security check on dusk each afternoon shift. Additional security measures included visitors signing in and out, staff wearing the organisations uniforms and name badges, and security lighting.</p>
<p>Subsection 5.1: Governance</p> <p>The people: I trust the service provider shows competent leadership to manage my risk of infection and use antimicrobials appropriately.</p> <p>Te Tiriti: Monitoring of equity for Māori is an important component of IP and AMS programme governance.</p> <p>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.</p>	FA	<p>The organisation identifies the infection prevention (IP) and antimicrobial stewardship (AMS) programmes as integral to improving the quality of services delivered to all people in their services and this was confirmed in interview with senior leadership. Infection prevention issues are escalated through new clinical reporting lines to the clinical leader (refer 3.2.3).</p> <p>Strategic direction and advice to the clinical leader is through national bodies accessed. These include the regional, and national experts and other health service providers.</p> <p>The facility's infection prevention team consists of the clinical manager (CM) who reports to the national clinical manger. Reporting includes activities, outcomes, and overall response effectiveness to outbreaks and infections. There has been a recent outbreak which was in the process of review at the time of the audit.</p> <p>Significant IP events are managed using a stepwise approach to risk</p>

		<p>management and receive the appropriate level of organisational support. Ethnicity data is collected for infections and reported through established reporting mechanisms such as the Reflection Report. Major events such as COVID -19 have been escalated to the board.</p> <p>Antimicrobial stewardship policy is in place (refer 5.3.3).</p>
<p>Subsection 5.2: The infection prevention programme and implementation</p> <p>The people: I trust my provider is committed to implementing policies, systems, and processes to manage my risk of infection.</p> <p>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.</p> <p>As service providers: We develop and implement an infection prevention programme that is appropriate to the needs, size, and scope of our services.</p>	FA	<p>The infection prevention and control team (IPCT) on site are responsible for implementing the infection prevention programme/plan which is linked to the quality programme. The team meets monthly and reports through the CM to the national CM. Staff confirmed the escalation process related to IPC issues and how this occurs through the national CM and to the clinical advisory group. There are defined responsibilities for IPC decision making that include clinical advisory.</p> <p>The roles and responsibilities for the infection prevention and control (IPC) lead, the CM, are established with the current IPC lead job description. The CM has completed training with an external provider. Orientation and mandatory IPC training has been completed for staff including RNs, health care assistants (HCA,) cleaning, laundry, kitchen, and activity staff.</p> <p>Interviews with members of the IPCT confirmed the monthly meetings included pandemic issues/updates when necessary. Information support is available through the local primary health services including public hospital IP clinical nurse specialist (CNS). Secondary support was through the primary health services and public health services. Information resources such as COVID-19 facility requirements are available to residents in te reo Māori.</p> <p>Infection prevention audits including hand hygiene are completed. There is a process to review outcomes and audit compliance. Audit outcomes are benchmarked against other UCG facilities, and this information is available to the facility staff. Reauditing occurs as required.</p> <p>A suite of current policies and procedures guide IPC practice. Outbreak management and plans are implemented as needed in a timely manner. The management and oversight of outbreaks is supported by the senior staff. Required reporting for outbreaks is completed including section 31</p>

		<p>reporting and this was confirmed through interview and document review.</p> <p>Cultural advice is accessed to ensure the IPC programme is culturally safe. The IPCT attend relevant education and where appropriate the IPCT members reported they could provide input into new projects/renovations.</p> <p>Senior clinical staff with IPC training/education inform the organisations decision making related to the procurement of IPC resources. The reuse of single use items is managed according to policy and meets the intent of standards. This includes a risk assessment where appropriate.</p> <p>Appropriate supplies of personal protective equipment (PPE) are available in each wing. Observation confirmed these were appropriately used including masks, aprons, and gloves. There are ample reserves onsite and a system and process in place if additional stock is required.</p> <p>A range of interventions have occurred in relation to COVID-19 including visitor testing as required. Processes continue to be reviewed and changed in line with current accepted practice and national guidelines with different variants emerging including the national staff testing programme.</p> <p>The IPC policies reviewed meet the requirements and were based on current accepted good practice. They are available to staff with multiple electronic devices in use across the facility for timely access. The IPCT have input into other relevant clinical IPC documents including policies and procedures. Cleaning and laundry management policies are in place. All staff interviewed reported their responsibilities regarding infection prevention.</p>
<p>Subsection 5.3: Antimicrobial stewardship (AMS) programme and implementation</p> <p>The people: I trust that my service provider is committed to responsible antimicrobial use.</p> <p>Te Tiriti: The antimicrobial stewardship programme is culturally safe and easy to access, and messages are clear and relevant.</p> <p>As service providers: We promote responsible antimicrobials</p>	PA Low	<p>There is an antimicrobial stewardship (AMS) policy in place which identifies the organisations goals to optimise antimicrobial use and to minimise harm. The policy is approved by the board and developed using evidence-based guidance. The organisations goals are suitable for the size and scope of services provided.</p> <p>Infection data is collected monthly by the CM. Quality documents reviewed evidenced information related to antibiotics is not yet collected</p>

prescribing and implement an AMS programme that is appropriate to the needs, size, and scope of our services.		(Refer 5.3.3) Staff outlined how cultural advice is accessed when indicated, to ensure the IPC programme remains culturally safe. The IPCT attend relevant education for IPC and AMS (April 2023). All new staff receive induction/orientation including infection prevention and this is available on-line. The IPCT/CM provide planned and opportunistic education for staff. Ethnicity data is collected across the organisation and confirmed in the onsite data sighted. Staff were interviewed were informed around antibiotic prescribing and the increase of multi drug resistant organisms.
<p>Subsection 5.4: Surveillance of health care-associated infection (HAI)</p> <p>The people: My health and progress are monitored as part of the surveillance programme.</p> <p>Te Tiriti: Surveillance is culturally safe and monitored by ethnicity.</p> <p>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.</p>	FA	<p>Surveillance activities are undertaken by staff and detailed in the infection prevention and control programme. This includes monitoring positive results for infections and outbreaks as well as the inclusion of ethnicity data. Standard definitions are used.</p> <p>Methods for surveillance are documented in policies and procedures.</p> <p>Variances in trends in surveillance data are identified. Results of surveillance are communicated to the IPCT, to staff and the senior leadership team (SLT). There is reporting to clinical advisory as required.</p> <p>The clinical manger discussed the increasing rates of skin infections and the response undertaken including education /training for staff.</p> <p>Staff interviewed were satisfied that any urgent issues would be escalated to governance in a timely manner via the clinical lead.</p> <p>Members of the senior leadership team discussed infection information, trends, and the programme. Culturally safe communication processes are outlined within the Māori health plan when required for residents with healthcare associated infections (HAI).</p>
<p>Subsection 5.5: Environment</p> <p>The people: I trust health care and support workers to maintain a hygienic environment. My feedback is sought on cleanliness within the environment.</p> <p>Te Tiriti: Māori are assured that culturally safe and appropriate decisions are made in relation to infection prevention and</p>	FA	<p>The provider implements UCG waste and hazardous management policies which comply with legislative and local council requirements. Policies include but are not limited to considerations of staff orientation and education, incident/accident and hazards reporting, use of PPE, disposal of general, infectious and hazardous waste. Staff receive training and education in waste management and infection control as a</p>

<p>environment. Communication about the environment is culturally safe and easily accessible.</p> <p>As service providers: We deliver services in a clean, hygienic environment that facilitates the prevention of infection and transmission of antimicrobialresistant organisms.</p>		<p>component of the mandatory training. Yellow containers for sharps and syringes were viewed in clinical areas. The processes to manage these were confirmed.</p> <p>Current material safety data information sheets are available and accessible to staff in relevant places, such as laundry and the sluice room. Staff complete a chemical safety training module on orientation.</p> <p>Interviews and observations confirmed that there is enough PPE and equipment provided such as aprons, gloves, and masks. Interviews confirmed that the use of PPE was appropriate to the recognised risks. Observation confirmed that PPE was used in high-risk areas.</p> <p>Laundry and cleaning services were provided seven days a week. All laundry was managed on site. Rosters sampled outlined that laundry and cleaning have rostered part time staff throughout the week. Visual inspection of the laundry demonstrated the implementation of a clean/dirty process for the hygienic washing, drying and handling of all laundry. The safe and hygienic collection and transport of laundry items into relevant labelled containers was witnessed. Staff interview evidenced staff awareness of the process to handle and wash infectious items. Laundry audits were completed. Clean linen is stored appropriately in hall cupboards with linen trolleys covered when in use. Resident's clothing was labelled and personally delivered from the laundry as observed. Feedback from residents' surveys and interviews confirmed satisfaction with laundry services.</p> <p>Cleaning duties and procedures were documented to ensure correct cleaning processes occur. There are designated locked cupboards for the safe and hygienic storage of cleaning equipment and chemicals. Housekeeping personnel interviewed were aware of the requirement to keep their cleaning trollies in sight. Chemical bottles in storage and in use were noted to be appropriately labelled.</p> <p>There is policy to provide direction and guidance to safely reduce the risk of infection during construction, renovation, installation and maintenance activities. It details consultation by the infection prevention team with the CSM having overall responsibility for the facility. There was no construction, installation, or maintenance in progress at time of audit.</p>
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<p>Subsection 6.1: A process of restraint</p> <p>The people: I trust the service provider is committed to improving policies, systems, and processes to ensure I am free from restrictions.</p> <p>Te Tiriti: Service providers work in partnership with Māori to ensure services are mana enhancing and use least restrictive practices.</p> <p>As service providers: We demonstrate the rationale for the use of restraint in the context of aiming for elimination.</p>	FA	<p>There are policies, procedures, systems, processes in place to guide practice related to the use of restraint. The organisation has a restraint philosophy aimed towards a restraint free environment. All restraint practice is managed through an established process consistently across all UCG facilities.</p> <p>When restraint is considered at facility level, the decision-making escalation process requires input from senior staff (the lead clinician). Staff interviews including members of the restraint team confirmed the organisations approach to the elimination of restraint and management of behavioural challenges through alternative means. They also confirmed the decision-making process includes a variety of opportunities to explore non- restraint methods including a non-pharmacological approach. The safety of residents and staff is always considered by the restraint team, and this was discussed.</p> <p>Records confirmed training related to challenging behavioural and communication has been completed annually. Staff reported they were trained and competent to manage challenging behaviours. Residents who had challenging behaviour identified in their plans of care had strategies documented to ensure they were well supported to avoid challenging experiences.</p> <p>Staff confirmed they were aware of avoiding pharmacological remedies for challenging behaviours where at all possible. Medications such as antipsychotics are recorded and benchmarked. Alternative measures to support residents are documented in each resident's clinical file and progress notes support the strategies undertaken to respond.</p> <p>Staff interviewed, confirmed the processes required for Māori residents when considering restraint or if restraint practice was implemented. Discussion included staff commitment to ensuring the voice of people with lived experience, Māori and whānau, would be evident on any restraint oversight group, and how this would be achieved through onsite Māori staff and/or community support.</p> <p>Executive leaders receive restraint reports monthly alongside aggregated restraint data, including the type and frequency of restraint if restraint has occurred. This forms part of the regular Reflection Report.</p>

		There were no episodes of restraint recorded since the last audit or in living memory of staff interviewed. Restraint is only considered a last resort.
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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)
<p>Criterion 3.2.3</p> <p>Fundamental to the development of a care or support plan shall be that:</p> <p>(a) Informed choice is an underpinning principle;</p> <p>(b) A suitably qualified, skilled, and experienced health care or support worker undertakes the development of the care or support plan;</p> <p>(c) Comprehensive assessment includes consideration of people's lived experience;</p> <p>(d) Cultural needs, values, and beliefs are considered;</p> <p>(e) Cultural assessments are completed by culturally</p>	<p>PA</p> <p>Moderate</p>	<p>The organisation has clinical indicator monitoring in place that is incidence based. Clinical staff onsite reported during interview that this occurs to highlight clinical risks related to resident care and ensure that risks identified are responded to in a timely manner.</p> <p>Recent data for November 2023 (Reflections Report) included data related to high rates of skin infections, pressure injuries/wounds and falls for UCG Aroha. The total number of residents affected by clinical indicators was discussed. Clinical files sampled and the wound register confirmed twenty-two wounds, fourteen of which were skin tears. Two residents had more than one wound. There was evidence for one tracer resident, that a tissue viability assessment had been received electronically utilising uploaded visual images (photos).</p>	<p>Risks identified through clinical indicators are not always responded to in a timely manner across the facility to ensure clinical risks are managed to reduce resident harm.</p>	<p>Ensure clinical indicators are utilised and responded to in a timely manner to ensure residents risk of harm is minimised.</p> <p>90 days</p>

<p>competent workers and are accessible in all settings and circumstances. This includes traditional healing practitioners as well as rākau rongoā, mirimiri, and karakia;</p> <p>(f) Strengths, goals, and aspirations are described and align with people's values and beliefs. The support required to achieve these is clearly documented and communicated;</p> <p>(g) Early warning signs and risks that may adversely affect a person's wellbeing are recorded, with a focus on prevention or escalation for appropriate intervention;</p> <p>(h) People's care or support plan identifies wider service integration as required.</p>		<p>Medical personnel interviewed provided comment around staff changes and availability may have influenced the increased incidence of infections, wounds, falls and medication errors.</p> <p>Clinical staff reported an organisation wide restructure had taken place mid-year 2023 which included the disestablishment of regional clinical roles and development of clinical coaches to provide clinical practice support for facility teams. The clinical manager interviewed, identified a new direct reporting line to the organisations clinical lead.</p> <p>A plan to respond to the collective data around the increased clinical indicators was not identified at the time of the audit. Support from the clinical coach was in place and included fortnightly visits to assist with wound assessments. However, clinical plans and overall accountabilities for the clinical outcomes for all the facility's clinical indicators had not been clearly identified by onsite staff.</p>		
<p>Criterion 3.4.1</p> <p>A medication management system shall be implemented appropriate to the scope of the service.</p>	<p>PA Moderate</p>	<p>It was noted that a medication error had occurred involving a controlled drug in elixir form. The incident, although clinically investigated and documented in a word document, was not entered into the quality and risk system utilising the investigation template required and not all staff were aware of the event including the facility manager. The outcome of the investigation did not identify areas of improvement.</p>	<p>Medication error reporting was not completed according to UCG policy and or organisational reporting requirements.</p>	<p>Ensure medication errors are managed to meet requirements.</p> <p>30 days</p>
<p>Criterion 5.3.3</p>	<p>PA Low</p>	<p>Infection prevention and control data is collected</p>	<p>Antibiotics, when</p>	<p>Ensure all information</p>

<p>Service providers, shall evaluate the effectiveness of their AMS programme by:</p> <p>(a) Monitoring the quality and quantity of antimicrobial prescribing, dispensing, and administration and occurrence of adverse effects;</p> <p>(b) Identifying areas for improvement and evaluating the progress of AMS activities.</p>		<p>and analysed. Staff interviewed reported that antibiotic use was not yet collected to inform the AMS programme. The medication management system in use can capture antibiotic prescribing, allergies/sensitivities for the AMS programme. It was not confirmed onsite that this is currently occurring to inform the AMS programme.</p>	<p>prescribed, are not included in information currently required for the AMS programme.</p>	<p>pertaining to antibiotic prescribing is included in the information required for the AMS programme reporting.</p> <p>180 days</p>
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.