

The Ultimate Care Group - Ultimate Care Lakewood

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 Lakewood	
Services audited:	Dementia care	
Dates of audit:	Start date: 13 February 2024	End date: 14 February 2024
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:	27	

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
Yellow	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
Red	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 Lakewood is part of the Ultimate Care Limited having been acquired by the group in April 2023. It is certified to provide care for up to 36 residents requiring rest home dementia level care. The facility manager has been in the role for three weeks and is currently completing the organisational and site-specific orientation programme. Additionally, the organisation has had a vacancy within its clinical governance space and have undertaken a recruitment campaign to fill this gap.

This is the first certification audit under Ultimate Care Limited ownership and was conducted against the Ngā Paerewa Health and Disability services standard NZS8134:2021 and the provider contracts with Te Whatu Ora – Waitaha Canterbury. The audit process included review of policies and procedures, review of resident and staff records, observations, and interviews with whānau, a general practitioner and the national programmes manager for Ultimate Care Limited. No residents were able to be interviewed due to cognitive or mental health issues. 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 resident admission documentation, infection prevention programme implementation, surveillance data reporting and laundry management.

Ō tātou motika | Our rights

<p>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.</p>		<p>Some subsections applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The service complies with Health and Disability Commission Code of Health and Disability Consumers Rights (the Code). Residents receive services in a manner that considers their dignity, privacy independence and facilitates 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 that focused on the individual and considered values, beliefs, culture, religion, and relationship status.

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

Hunga mahi me te hanganga | Workforce and structure

<p>Includes five subsections that support an outcome where people receive quality services through effective governance and a supported workforce.</p>		<p>Subsections applicable to this service fully attained.</p>
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Ultimate Care Group is the governing body responsible for services provided. The organisation’s mission statement and vision were documented and displayed. The Provider has business and quality risk management plans.

Whilst the facility manager is undergoing the orientation programme the regional manager is providing additional support. The clinical services manager was responsible for the provision of clinical services.

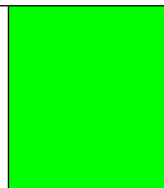
Quality and risk systems were in place. Meetings were held that included reporting on various clinical indicators, quality and risk issues and there was review of identified trends.

There were human resource policies and procedures that guide practice in relation to recruitment, orientation, and staff management. An organisation wide training schedule was implemented which was appropriate for the residents. There was always a sufficient number of staff on site with provision of afterhours support for clinical and operational issues.

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

Ngā huarahi ki te oranga | Pathways to wellbeing

Includes eight subsections that support an outcome where people participate in the development of their pathway to wellbeing, and receive timely assessment, followed by services that are planned, coordinated, and delivered in a manner that is tailored to their needs.



Subsections applicable to this service fully attained.

Information was provided in accessible formats to residents and their whānau on entry. The registered nurse assessed residents on admission with input from the resident and/or whānau. The initial care plan guided care and service provision during the first three weeks after admission.

InterRAI assessments were used to identify residents' needs and these were completed within the required timeframes. The general practitioner completed a medical assessment on admission and reviews occurred thereafter on a regular basis. Long term care plans were developed and implemented within the required timeframes. Residents' files sampled demonstrated evaluations were completed at least six-monthly. Handovers between shifts guided continuity of care and teamwork was encouraged.

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

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

An electronic medication management system was in place. Medications were administered by the registered nurse, the enrolled nurse and caregivers who had completed current medication competency requirements.

The food service met the nutritional needs of the residents. All meals were prepared on-site. Residents and family/whānau confirmed satisfaction with meals provided.

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 an appropriate environment. A reactive and preventative maintenance programme was implemented. External areas provide safe seating and shade with residents able to walk freely around the perimeter of the facility whilst security was maintained.

Resident rooms were of an appropriate size and allowed room for personal memorabilia and additional furniture. 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 residents and staff to access help when required. Security systems were in place and staff were trained in emergency procedures and use of equipment/suppliers. 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 always a staff member with a current first aid certificate on duty.

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

<p>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.</p>		<p>Some subsections applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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There were infection prevention policies and procedures to guide staff.

Infection data was collated, analysed, trended, and reported to the Board. Antimicrobial prescribing was monitored. Monthly surveillance data was reported to staff.

There were organisational COVID-19 prevention strategies in place including a pandemic plan.

There had been two outbreaks since the last audit, norovirus, and COVID-19.

Here taratahi | Restraint and seclusion

<p>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.</p>		<p>Subsections applicable to this service fully attained.</p>
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Restraint minimisation and safe practice policies and procedures were in place. Ultimate Care Group Limited maintain a clear stance that all facilities only use restraint as a last resort with an overall aim that they remain restraint free. Restraint minimisation was overseen by the restraint coordinator. On the day of the audit, there were no residents using a restraint. Restraint would only be used as a last resort when all other options had been explored.

Staff had completed restraint elimination and safe practice training. Information related to restraint was available at governance level and to facility staff. Quality meetings included restraint practice.

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	23	0	2	2	0	0
Criteria	0	165	0	2	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>	<p>FA</p>	<p>Staff received training in cultural safety at orientation. The organisation had developed a cultural safety module that was provided as part of the education programme. It defines and explains cultural safety and its importance including Te Tiriti o Waitangi. Training records sampled evidenced that all staff had completed this except for new staff who were completing an orientation programme.</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 shall be encouraged. The regional manager (RM) who provided support for the newly appointed facility manager (FM) for this audit outlined how this was implemented. The plan describes the aims of UCG to ensure outcomes for Māori are 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 that identifies as Māori would have the opportunity to have whānau involved in their care. There were residents residing in the facility at time of audit who identified as Māori.</p>

		The Diversional therapist (DT) outlined that significant gains have been made to establish formal links with local iwi of the region at Rehua marae, and PuruPuru Whetu Trust.
<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 and collaboration. The DT outlined what Pacific community connections were in place with Etu Pasifika and how this organisation was actively engaged with current residents who identified as Pacific.</p> <p>The organisation has developed a strategy that ensures a Pacific health and wellbeing workforce was recruited and retained across the organisation. The RM outlined how this was implemented.</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 throughout the facility written in English and Te re Māori.</p> <p>Staff discussed the Code and gave examples of how they met the Code when providing day to day care. Observation during the audit confirmed that care was provided in accordance with the Code. Staff records sampled evidenced that training regarding the Code formed part of the orientation schedule. Staff interview and review of admission packs confirmed that information regarding the Code was included in all packs with further explanation given by staff in regards what this means in relation to care delivery. Further discussion confirmed that whānau and/or enduring power of attorney (EPOA) had been consulted about their relative's care plan and were involved in discussions regarding their care.</p> <p>Staff outlined that they were aware of the advocacy service and gave examples of when this support would be beneficial. The DT outlined that the provider has engaged two advocates one of whom provides support</p>

		<p>for Māori residents. Contact details were available for local and national advocacy support people. The RM outlined that representatives from the local national advocacy service deliver education to the staff on site.</p> <p>Policy and practice include ensuring that all residents, including any Māori residents, right to self-determination is upheld and they can practise their own 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>	<p>FA</p>	<p>The Provider ensured that residents where possible and whānau/EPOA were involved in planning and care which was inclusive of discussions and choices regarding maintaining their independence. 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 residents rights to privacy and dignity were upheld. Staff and whānau interviews plus observation confirmed that staff knock on doors before entering, address residents using their preferred name and maintain confidentiality when holding conversations that are 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 compliance to complete this was monitored by head office and the FM was advised when staff were yet to complete this. Staff were encouraged to learn and use basic greetings in te reo Māori. All signage throughout the facility was in te reo Māori and English. A large notice board by the main resident lounge contained information of the history of local iwi in the area, and Māori cultural services available.</p> <p>The organisation supports tangata whaikaha to do well with documentation outlining how staff work in partnership with residents to ensure strengths and abilities are maintained for as long as is possible. Evidence of how this was achieved was evident within resident records</p>

		sampled.
<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>	<p>PA Moderate</p>	<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 provides clear expectations regarding management responsibilities of personal property and finances. However not all resident agreements have been transitioned to UCG paperwork. The resident EPoA provides 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. Whānau interviewed 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 that these were signed. Staff mandatory training included maintaining professional boundaries. Discussion with staff confirmed their understanding of professional boundaries relevant to their respective roles. Whānau interviewed confirmed that professional boundaries were maintained.</p> <p>Whānau interviewed described how they feel confident their relative was in safe hands and were complimentary regarding the level of care. Whānau provided further evidence that they feel comfortable to raise any issues and discussions were free and open.</p> <p>The Māori health plan promotes a strengths based and holistic model of care for Māori. Resident files sampled confirmed that care was provided</p>

		using a holistic model and resident's strengths were focused on.
<p>Subsection 1.6: Effective communication occurs</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>	FA	<p>There was policy to ensure that residents and their whānau have the right to comprehensive information supplied in a way that was appropriate and considered specific language requirements and disabilities. The RM confirmed that if required interpreters were accessed from Te Whatu Ora Waitaha Canterbury.</p> <p>Resident records sampled that other health 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/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 meetings were scheduled, and review of documentation and staff interview evidenced these had occurred as per schedule. High numbers of whānau had attended with a small but appropriate number of items raised for discussion outlined within the meeting minutes. Whānau interviewed they found the meetings helpful to ensure they found out what was happening within the facility and felt an added sense of connection with the facility to staff, other residents and their whānau. Meetings were advertised in the activities planner with reminders of what is coming up placed on noticeboards. Both facility advocates attend these meetings as able. Copies of the menu and activities plan was made available to residents and 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</p>	FA	<p>The informed consent policy was in line with the Code. The policy outlined how staff were to ensure residents and/or whānau were to be given time and appropriate information to enable informed consent for all aspects of care. Resident records sampled included signed consent for photographs, collection and storage of informed consent and outings.</p> <p>All resident records sampled contained the details of the named enduring power of attorney (EPoA) all of which had been activated. The</p>

<p>messages so that individuals and whānau can effectively manage their own health, keep well, and live well.</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>clinical nurse manager (CSM) was fully conversant with the necessary legal requirements of an EPoA. The resident's resuscitation status was documented and signed by the general practitioner (GP).</p> <p>The CSM and staff interviewed were able to outline tikanga guidelines and that this had been a component of their orientation and in-service education. Whānau/EPoA confirmed they were given sufficient information and timeframes, within a suitable format to make decisions appropriate to their relatives care.</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 to whānau by the clinical services manager (CSM). Complaint forms were easily accessed within the facility with reminders about the complaints process available in poster form throughout the facility. Whānau interviewed confirmed they had been made aware of the complaint process and felt they were encouraged to provide feedback and raise concerns when required. The DT confirmed that support was readily available for Māori residents/whānau to navigate the complaints process.</p> <p>All complaints received are logged on the electronic system. The complaints register was reviewed with one complaint being received since UCG ownership in April of 2023. The complaint had been managed in accordance with UCG complaints policy and procedure. Evidence was provided that the complainant had been informed of the outcome and the complaint had been closed. Corrective actions had been put in place in response to the complaint being raised. There were no open complaints at time of audit.</p> <p>The RM advised that one Health and Disability Commission (HDC) complaint that had been lodged prior to UCG ownership in November 2022 had been closed by HDC in July 2023.</p>
<p>Subsection 2.1: Governance</p>	<p>FA</p>	<p>Ultimate Care Lakewood is part of Ultimate Care Group which is a New Zealand registered company. There is governance structure in place</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>	<p>which monitors compliance with legislative, contractual, and regulatory requirements. There was Māori representation at governance level providing guidance to the organisation to ensure actions were embedded across the organisation that enacts the principles of Te Tiriti o Waitangi. The national programme manager advised that UCG continues to focus on the organisation’s obligations under Te Tiriti o Waitangi and cultural safety. The governance structure has had one change with the appointment of a new national clinical lead imminent. An executive team provides direction to the Provider.</p> <p>The annual strategic business plan has key outcomes which are resident centred, such as health and safety, complaints, education, and fiscal stability. These were monitored at board meetings.</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 were encouraged to learn and use basic Māori greetings and continue to upskill in Māori tikanga. Whānau are encouraged to have input into service improvement as confirmed by staff and whānau.</p> <p>The UCG management team have seven clinical coaches across the organisation to provide clinical support and mentorship. The CSM confirmed this support was valued. The clinical coaches ensure key indicators are disseminated to the national clinical lead. Whilst recruitment has been underway for this current gap the general manager (GM) has taken responsibility for the management of this information.</p> <p>The new FM has a background in health sciences. The RM was providing support to the facility whilst the FM was undertaking orientation and provided support for the audit. The FM reports to the RM who has weekly online meetings with all managers in the allocated region with regular face to face contact. The CSM has a background in aged care and has been in the role for two years.</p> <p>The organisation has implemented robust systems to support quality and risk management structure with a wide range of information gathered to</p>
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		<p>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 tangata whaikaha with the goals and actions required described and the support required to achieve aspirations and reduce barriers. The organisation continues to focus on the need to prioritise the building of relationships with Māori disability stakeholders.</p> <p>The provider is certified to provide dementia rest home level care for up to 36 residents. On day of audit there were 27 residents under the age-related residential care agreement with Te Whatu Ora – Waitaha Canterbury.</p> <p>The Provider receives oversight/support from Te Whatu Ora gerontology nurse specialists.</p>
<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>	<p>FA</p>	<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. UCG Lakewood is yet to complete a residents/relatives satisfaction survey as this is completed annually and was due four weeks after taking ownership. It is due for completion later this year.</p> <p>There was an implemented annual schedule of internal audits. Areas of non-compliance including the implementation of a corrective action plan and sign off was the responsibility of the CSM. A reporting tool captures a broad range of information across all UCG facilities.</p> <p>The CSM took the responsibility for health and safety for the facility and had a signed job description for the role. The Provider has made a commitment to ensuring all staff were aware of the importance of health and safety with a continued focus on minimising accidents or incidents.</p> <p>The Provider had a set schedule of meetings in place including quality,</p>

		<p>health and safety, staff, residents/whānau. Meeting minutes outlined who attended, what was discussed who was taking responsibility for follow up and when the issue was closed.</p> <p>The organisation follows the UCG adverse event reporting policy for internal and external reporting. The RM confirmed a section 31 was completed for the recent appointment for the FM and expressed an understanding of what other events constituted the need for section 31 reporting.</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 followed 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 safe staffing levels were maintained. Review of rosters evidenced that unplanned absences were covered appropriately by part time staff working additional hours.</p> <p>The FM works 40 hours per week and will provide after-hours support for operational issues once the orientation process is completed. The RM is providing this support until then. The CSM works 40 hours and provides after hour support for clinical issues in conjunction with an enrolled nurse (EN). The morning shift comprised of one enrolled nurse or a senior care giver/shift lead, and four care givers, the afternoon shift comprised of one shift lead and three caregivers with the night shift led by a shift lead with one care giver. The shift leaders had current medication competencies, had current first aid certificates, and had completed additional UCG training in STOP and WATCH acute deterioration assessment policy which is inclusive of guidelines for the escalation pathway when required for residents of concern. Nonclinical staff included housekeeping, laundry, and kitchen personnel. The maintenance role was vacant with a recruitment campaign underway to</p>

		<p>fill this vacancy. The activities programme ran five days per week managed by the DT and an activities co-ordinator. Laundry and cleaning staff were rostered part time across the week. Interviews with whānau and staff advised they were not aware of any staffing issues impacting on residents or service delivery.</p> <p>There was an implemented training programme. Staff competencies, training and education scheduled were relevant to the needs of dementia residents. Staff attendances for training delivered over the last twelve months was reviewed and evidenced training was up to date for most staff with a plan in place that ensures staff non-compliance with training was monitored and actioned. Current cultural safety training schedule provides staff with resources to support their practice to achieve equitable health outcomes. The CSM and EN have completed InterRAI training.</p> <p>The Provider collects both staff and resident ethnicity data via an 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>	<p>FA</p>	<p>The organisations human resource systems and polices outline the principles of good employment practice and the Employment Relations Act 2000. Staff records sampled evidenced that policy and procedure had been consistently followed. Staff employed at the facility prior to UCG ownership had their employment details transitioned to UCG contracts and organisational requirements.</p> <p>The recruitment process includes police vetting, reference checks, and validation of annual practising certificates/qualifications. Current practising 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 driver's licences without any driving convictions and first aid certificates.</p> <p>There was a documented and implemented orientation programme and staff records evidenced orientation was completed. Orientation covered</p>

		<p>the essential components of service delivery with specifics relating to their roles included. Staff confirmed completing this and advised it was appropriate to their role. Should the Provider utilise agency nursing staff there was separate policy and plan for their orientation if required.</p> <p>Annual performance reviews were completed for all staff requiring these and three-monthly reviews had been carried out for newly appointed staff.</p> <p>Staff interview and review of documentation evidenced that staff ethnicity data was collected, and review of staff records provided additional information this was in place.</p> <p>The RM confirmed that a debrief process could be put in place when required.</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>	FA	<p>Resident's records and medication charts were managed electronically. Resident 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 their 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/EPoA. Other information including assessments and reports from other health professionals were included within the resident record.</p> <p>The Provider gathers information on admission regarding a resident's ethnicity which was reported through to UCG head office. The Provider was not required to gather data requiring the national health index (NHI).</p>
Subsection 3.1: Entry and declining entry	FA	On enquiry, an information booklet detailing entry criteria was provided

<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>to prospective residents and their whānau. This information was also available on the internet.</p> <p>On admission residents and their whānau were provided with written and verbal information with any questions raised answered by staff. Admission packs provided comprehensive information written in plain language, citing key messages. The information was also available in Te Reo Māori. Interpreters were available via Te Whatu Ora Waitaha as required to ensure 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. Review of residents' files confirmed that entry to service complied with entry criteria. Information relating to admission, discharge and decline rates was analysed by the board via the monthly reporting system.</p> <p>Whānau interviewed reported they were treated with respect and kept informed throughout the admission process and understood the rationale for information required during the process, for example Enduring Power of Attorney (EPOA) status.</p> <p>The service had a process in place if access was declined. If a person was declined access to the service, the person, their whānau and the referring agency would be informed. Alternative services where possible were offered and documentation of reason is maintained in internal files. A person would be declined entry if not within the scope of the service or if a bed was not available. The clinical services manager (CSM) explained that no persons had been declined entry since the last audit. Declining of admissions would be reported as part of the UCG monthly report.</p> <p>The admission policy required the collection of information that included but is not limited to ethnicity; spoken language; interpreter requirements; iwi; hapū; religion; and referring agency. Interviews with whānau and review of records confirmed the admission process was completed in a timely manner. Ethnicity, including Māori, was being collected and analysed.</p> <p>Lakewood had established relationships with Nga Hau e Wha (National) Marae, and with local Māori health providers, for example, PuraPura Whetu Trust (mental health), Te Whare Roimata Trust (older persons</p>
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		health care), Te Puna Oranga (counselling services) and Rehua Marae (traditional Māori healing) to ensure appropriate support for tāngata whenua.
<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>	FA	<p>Ultimate Care Group has developed a model of care specific to older persons. Staff interviewed described the model of care and how the model informed care delivery. Resident care plans were developed using an electronic system. The CSM was responsible for all residents' assessments, care planning and evaluation of care.</p> <p>Initial care plans were developed within the required timeframe. They were based on data collected during the initial nursing assessments and on information from pre-entry assessments completed by the needs assessment co-ordination service (NASC) or other referral agencies. The assessments included information about, but not limited to, the resident's medical history, pain, nutrition, mobility, skin condition, early warning signs (EWS), cultural needs, spiritual wellbeing, and documentation of the resident's life experience. Assessments sampled had been completed in consultation with the resident and whānau.</p> <p>The residents' activities assessments were completed by the diversional therapist (DT) in conjunction with the CSM following the residents' admission. Information on residents' interests, whānau, and previous occupations was gathered during the interview with the resident and their whānau and documented. The activity assessments included a cultural assessment which gathers information about cultural needs, values, and beliefs. Information from these assessments was used to develop the resident's individual activity care plan. The residents' activity needs were reviewed six monthly at the same time as the care plans and were part of the formal six-monthly multidisciplinary review process.</p> <p>The individualised long term care plans (LTCPs) were developed with information gathered during the initial assessments and from the interRAI assessment. Documented interventions and early warning signs met the residents' assessed needs. Short term care plans were developed for acute problems for example infections, post-fall care or weight loss.</p> <p>The initial medical assessment was completed by the residents' general</p>

	<p>practitioner (GP) within the required timeframe following admission. Residents had reviews by the GP within required timeframes and when their health status changed. There was documented evidence of the exemption from monthly GP visits when the resident's condition was considered stable. The GP interviewed confirmed that there was good communication with the service, they were informed of concerns in a timely manner and that care was of a good standard. The Provider had access to an after-hours service. A physiotherapist visits the facility weekly and reviews residents referred by the CSM. A podiatrist visits the facility every six weeks.</p> <p>Staff interviewed and education records sighted confirmed that staff had access to cultural training. The provision of care reflected in the care plan was consistent with, and contributed to, meeting the residents assessed needs, goals, and aspirations. Support was identified for whānau. Staff discussed service provision to include providing services free from stigma and those which promote acceptance and inclusion.</p> <p>There was evidence of wound care products available. The review of the wound care plans evidenced wounds were assessed in a timely manner and reviewed at appropriate intervals. Photos were taken where this was required. Where wounds required additional specialist input, this was initiated.</p> <p>Nursing progress notes and medical notes were recorded and maintained in the electronic resident record. Monthly observations such as weight and blood pressure were completed and were up to date. Neurological observations were recorded following all unwitnessed falls. Any changes in the resident's condition were documented. There were escalation processes in place for clinical change and staff were able to discuss these. Clinical records sampled confirmed that where escalation had occurred this had been documented appropriately. Interviews with medical and nursing staff confirmed the process was undertaken consistently.</p> <p>Policies and protocols are in place to ensure continuity of service delivery. Staff interviews confirmed they are familiar with the needs of all residents and that they have access to the supplies and products they require.</p> <p>Resident care was evaluated on each shift, reported at handover and in</p>
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		<p>the progress notes. If any change was noted, it was reported to the CSM. Long term care plans were formally evaluated every six months in conjunction with the interRAI re-assessments and when there was a change in the resident's condition. Evaluations were documented by the CSM and included the degree of achievement towards meeting desired goals and outcomes. The clinical records sampled demonstrated that reviews of the resident care were ongoing. Handover meetings between each shift ensured residents progress towards meeting identified goals was discussed. 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 whānau interviews.</p> <p>The organisation had 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>A Māori health care plan was used for residents identifying as Māori. The care plan guided staff in gathering information and documenting the support required to meet the needs of residents who identified as Māori. Staff discussed their understanding of support required for Māori and whānau to identify their own pae ora outcomes in their care or support plan, and how these could be achieved and documented.</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>	<p>FA</p>	<p>The residents' activities programme was developed and implemented by a DT who was supported by an activities co-ordinator. Activities for the residents were provided between 8am and 5pm Monday to Friday. At weekends activities were provided by caregivers. The activities programme was displayed in the communal area and on the individual resident notice boards. The programme provided variety in the content and included a range of activities which incorporated education, leisure, cultural, spiritual and community events. For those residents who chose not to take part in the programme, one on one visits from the DT or activity co-ordinator occurred. All residents had a 24-hour activity plan in place.</p> <p>The programme was culturally diverse and tailored to the needs of the residents. Participation in the programme is encouraged. The DT has</p>

		<p>established links with several local groups and facilitates outings regularly to cultural events, for example, visits to the Ngā Hau e Whā National Marae and to Rehua Marae. A Pasifika group visit every two weeks. Cultural activities have included flax weaving and poi making. The DT has organised walks to the local golf club for afternoon tea, trips to local cafés and parks and to local places of interest, for example, the Airforce Museum. Church services were held weekly.</p> <p>Staff interviews confirmed that they had completed Māori cultural awareness education and that the involvement of Māori residents in the delivery of services is encouraged.</p> <p>Regular resident meetings are held and include discussion around activities. Whānau interviewed reported satisfaction with the activities provided. Over the course of the audit residents were observed engaging and enjoying a variety of activities.</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>FA</p>	<p>A current medication management policy identified all aspects of medicine management in line with relevant legislation, standards, and guidelines. A safe system for medicine management using an electronic system was observed. Prescribing practices were in line with legislation, protocols, and guidelines. The required three-monthly reviews by the GP were recorded electronically. Resident allergies and sensitivities were documented on the electronic medication chart and in the resident's electronic record.</p> <p>The service used pharmacy pre-packaged medicines that were checked by CSM on delivery. A system was in place for returning expired or unwanted medication. The medication refrigerator temperatures and medication room temperatures were monitored as per UCG policy and were within the required range.</p> <p>There was secure storage for controlled medications in accordance with requirements. Weekly checks of medications and six monthly stocktakes were conducted in line with policy and legislation.</p> <p>The staff observed administering medication demonstrated knowledge and at interview demonstrated clear understanding of their roles and responsibilities related to each stage of medication management. The</p>

		<p>RN oversaw the use of all 'as required' (PRN) medications and documentation made regarding effectiveness was sighted.</p> <p>Current medication competencies were evident in staff files. Education for residents/whanau regarding medications occurred on a one-to-one basis by the GP or CSM. Medication information for residents and whānau could be accessed from the contracted pharmacy and from Medsafe as needed.</p> <p>There was a UCG policy for self-administration of medications but no residents self-administer medication. There were no standing orders in place.</p> <p>The UCG medication policy describes use of over the counter (OTC) medications and traditional Māori medications and the requirement for these to be discussed with, and approved by, a medical practitioner. Interview with the GP and CSM confirm 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 whānau. If a Māori resident wished to use complementary Māori medications this would be discussed with the GP, CSM and EPOA prior to approval being given.</p>
<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>	<p>FA</p>	<p>A nutritional assessment was undertaken by the CSM for each resident on admission to identify dietary requirements, allergies / sensitivities, and preferences. The nutritional profiles were communicated to the kitchen staff and updated when a resident's dietary needs change. Diets were modified as needed and the cook confirmed awareness of the dietary needs, allergies/ sensitivities, likes and dislikes of residents. These were accommodated in daily meal planning.</p> <p>All meals were prepared on site and served in the dining rooms or in the residents' rooms. The temperature of food served was recorded. Residents were observed to be given sufficient time to eat their meal and assistance was provided when necessary. Residents and families/whānau interviewed stated that they were satisfied with the meals provided.</p> <p>The food service is provided in line with recognised nutritional guidelines</p>

		<p>for older people. The seasonal menu has been approved by a New Zealand Registered Dietician. The food control plan expiry date is June 2024.</p> <p>The kitchen was observed to be clean, and the cleaning schedules sighted. All aspects of food procurement, production, preparation, storage, delivery, and disposal sighted at the time of the audit complied with current legislation and guidelines. The cook was responsible for purchasing the food to meet the requirements of the menu plans. Food was stored and labelled appropriately in fridges and freezers. Temperatures of fridges and the freezer are monitored and recorded daily. Dry food supplies were stored in the pantry and rotation of stock occurs. All dry stock containers were labelled and dated.</p> <p>Discussion and feedback on the menu and food provided was sought individually by the cook, and at the residents' meetings. For Māori residents' information is gathered regarding nutritional needs and preferences during the initial assessment and during the development of their individual Māori health plan. The cook confirmed that Māori residents or their whānau could request culturally specific food, and any request would be accommodated.</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 were policies and processes that guide the transition, transfer, and discharge of residents. Staff interviewed were aware of the procedures required and discussed these during the audit.</p> <p>Records reviewed evidenced that transition, exit, discharge, or transfer was managed in a planned and coordinated manner and included ongoing consultation with whānau. The provider facilitated access to other medical and non-medical services. Whānau were advised of options to access other health and disability services, social support or Kaupapa Māori agencies if indicated or requested. Information regarding some of these services was on the residents' noticeboard. Staff interviewed were able to discuss other health and disability services and/or social support agencies that were suitable for the residents. When needed, referrals were sent to ensure other health services, including specialist care was provided. Referral forms and documentation were maintained on resident files. Referrals were</p>

		<p>regularly followed up.</p> <p>Interview with the CSM and review of residents' files confirmed there was open communication between services, the resident, and whānau. Relevant information was documented and communicated to health providers. For residents who are discharged into the community discharge documentation would be tailored to the individual circumstances and would include a medication chart and a care summary generated by the electronic system. For transfers to hospital the 'yellow envelope' system was used. Documentation included the resident's Ecase transfer form, medication chart, resuscitation status and EPOA information.</p>
<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>	<p>FA</p>	<p>The building warrant of fitness (BWOFF) was current to June 2024. Buildings, plant and equipment complied with the legislation relevant to the service being provided. A preventative and reactive maintenance schedule was implemented. The Provider has an electronic system in place to record all maintenance issues. Whilst the Provider has a vacancy for a maintenance person a neighbouring UCG maintenance person was ensuring the essential tasks for this role continued for example, hot water checks and was managing the maintenance requests logged. Staff confirmed awareness of the process and that issues were resolved in a timely manner. The RM was monitoring this process temporarily.</p> <p>Interviews with staff and visual inspection confirmed there was adequate equipment to support care. The facility had an up to date testing programme and tagging programme. There was a system in place to ensure that the facility van was routinely maintained, and the warrant of fitness and registration remained current. All staff who drive the van are required to have a driver's license with no previous driving convictions and a first aid certificate.</p> <p>Lakewood rest home is a secure dementia facility. The facility is set within a secure garden and residents were able to move freely between the garden areas and the facility. Outdoor areas included shade and seating and gardens evidenced recent maintenance. Ramps and handrails facilitate ease of access around all areas of the facility.</p>

		<p>Corridors and bedrooms have sufficient space to enable residents to mobilise safely and independently. There was a system to identify, report and manage hazards.</p> <p>The facility has adequate space for equipment, and both individual and group activities. This includes three lounges and two dining areas. Activities were observed to be held in the main lounge. Private, quiet spaces were available for residents to meet with their visitors and partake in cultural activities.</p> <p>There are three wings of single bedrooms. Some bedrooms have ensuite toilets and there are communal toilets and showers on each wing. Bedrooms sighted have sufficient space for the resident to manoeuvre and have been personalised with the residents' own ornaments and memorabilia.</p> <p>All resident rooms and communal areas 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 and whānau. The environment was noted to be maintained at a satisfactory temperature.</p> <p>In the event of additions to the facility Māori consultation could be accessed via established links within the community and assistance from head office.</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>	<p>FA</p>	<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 emergencies. Staff records sampled evidenced that staff had completed this. Fire drills and emergency evacuations were completed at least six monthly with the most recent one completed in January 2024. Emergency exit plans were visible throughout the facility.</p> <p>The evacuation plan had been approved by Fire and Emergency New Zealand (FENZ) in June 2005. There have been no structural alterations to the facility since that date. Fire extinguishers were strategically placed throughout the facility and had been checked within the last twelve</p>

		<p>months by a contracted service.</p> <p>Whānau were advised of the facility’s emergency responses as part of the admitting process of their relative. Notices were prominent throughout the facility advising visitors of what action to take in the event of an emergency providing a reminder on entering the facility. All shifts had at least one staff member on duty with a current first aid certificate. This was confirmed by staff records sampled and review of the staff rosters.</p> <p>The facility had acquired a generator to provide temporary power in the event of a power failure. The maintenance of this forms part of the maintenance person’s schedule. Sufficient supplies of water and food were stored to sustain residents and staff in the event of a civil defence emergency. Additional emergency resources include current civil defence kits, a gas heater, stove and barbeque. Adequate stocks of personal protective equipment, incontinence products, and dressings were sighted.</p> <p>There was a functioning call bell system in place which is routinely checked by the maintenance person. It was noted that staff responded promptly when call bells were activated during the period of the audit. Senior afternoon staff were responsible for ensuring a security check of the facility occurs on dusk each evening ensuring all windows and doors were locked. Security lighting, security stays on windows and regular checks on residents further enhance the security of the facility. Visitor access is open during the day with exit requiring knowledge of a keypad code.</p> <p>Staff confirmed their knowledge of security procedures.</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</p>	<p>FA</p>	<p>Infection prevention and control (IPC) and antimicrobial stewardship (AMS) are an integral part of the UCG strategic plan to ensure an environment that minimises the risk of infection to residents, staff, and visitors by implementing an infection prevention programme.</p> <p>The Ultimate Care Group senior leadership team (SLT) have as part of their senior management team personnel with expertise in IP and AMS. Expertise can also be accessed from “Bug Control” who supply the UCG</p>

<p>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>		<p>with infection control resources.</p> <p>There was a documented pathway for reporting IPC and AMS issues to the UCG Board. The onsite clinical team reported to the UCG clinical lead and the general manager who reported to the board. The UCG reflection report ensured that reporting occurs from governance back to site level.</p> <p>Policies and procedures were in place to manage IPC. Significant IPC events were managed using a stepwise approach to risk management and received the appropriate level of organisational support.</p> <p>External resources and support were available through external specialists, GP, wound clinical nurse specialist and Te Whatu Ora Waitaha when required. Overall effectiveness of the programme was monitored by the CSM</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. Te Tiriti: The infection prevention programme is culturally safe. Communication about the programme is easy to access and navigate and messages are clear and relevant. As service providers: We develop and implement an infection prevention programme that is appropriate to the needs, size, and scope of our services.</p>	<p>PA Low</p>	<p>The infection prevention and control programme was appropriate for the size and complexity of the service, however no documented annual infection prevention and control programme was in place.</p> <p>The UCG clinical operations group (COG) involved staff at site level in the review of policies and procedures and the infection prevention nurse (IPCN) had input when IP policies and procedures are reviewed,</p> <p>The CSM is the IPCN and has attended training for the role. A documented and signed role description for the IPCN was sighted. The IPCN reported to the clinical coach and UCG head of clinical. The IPCN was supported by the infection prevention committee which consisted of the FM, the EN and two caregivers who also undertake cleaning and laundry duties. Infection prevention reports were discussed at the facility's staff meetings. The IPCN had access to all relevant resident data to undertake surveillance, internal audits, and investigations. Staff interviewed demonstrated an understanding of the infection prevention programme.</p> <p>Policies and procedures reflected current best practice relating to infection prevention and included policies for hand hygiene, aseptic technique, transmission-based precautions, prevention of sharps injuries, prevention and management of communicable infectious</p>

	<p>diseases, management of current and emerging multidrug-resistant organisms (MDRO), outbreak management, single use items, healthcare acquired infection (HAI) and the built environment. Single use medical devices were not reused.</p> <p>Infection prevention resources including personal protective equipment (PPE) were available should a resident infection or outbreak occur. There were ample reserves onsite and a system in place if additional stock is required. The FM and IPCN had responsibility for purchasing equipment/resources for infection prevention in collaboration with the national office. Staff were observed to be complying with the infection prevention policies and procedures. Staff demonstrated knowledge on the requirements of standard precautions and were able to locate policies and procedures.</p> <p>The IPCN was responsible for coordinating/providing education and training to staff. The orientation package included specific training around hand hygiene and standard precautions. Annual infection prevention training was included in the mandatory in-service educations. Staff had completed infection prevention education in the last 12 months. The IPCN had access to an online training system with resources, guidelines, and best practice. Infection control audits had been completed. There was a process to review outcomes and audit compliance. Audit outcomes were benchmarked against other UCG facilities, and this information was available to the facility staff and to the board. Compliance with the audit schedule was confirmed through review of records and benchmarking data provided.</p> <p>Infection prevention and control representation included input into new buildings or significant changes occurred at local and national level and involved the FM and the senior leadership team.</p> <p>The outbreak and the pandemic plans had been implemented successfully during the COVID-19 pandemic and had been reviewed and tested at regular intervals. Two outbreaks had occurred since the previous onsite audit, norovirus, and COVID-19. The documentation reviewed confirmed these were managed to meet policy and contract requirements. Debriefing meetings were completed. Required reporting for outbreaks was completed including section 31 reporting and this was confirmed onsite through interview, and review of records and</p>
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		<p>documents.</p> <p>Hand sanitisers and gels were available for staff, residents, and visitors to the facility.</p> <p>Education for residents, including those who identified as Māori, regarding infections occurred on a one-to-one basis with whānau and included advice and education about hand hygiene, medications prescribed and requirements if appropriate for isolation.</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 prescribing and implement an AMS programme that is appropriate to the needs, size, and scope of our services.</p>	<p>FA</p>	<p>An antimicrobial stewardship programme (AMS) was in place. The AMS programme was developed and implemented to optimise antimicrobial use and to minimise harm. There were approved policies and guidelines for antimicrobial prescribing.</p> <p>Infection prevention and control data was collected and analysed. Once submitted it included all surveillance data such as the infection management system and AMS surveillance outcomes alongside audits for infections. The medication management system captured surveillance data on antibiotic prescribing, allergies/sensitivities for the AMS programme. Staff outlined how cultural advice was accessed when indicated to ensure the IPC programme remains culturally safe. All new staff received induction/orientation including infection prevention and this was available on-line. The ICPN provided planned and opportunistic education for staff.</p> <p>Prescribing of antimicrobial use was monitored, recorded, and analysed at site level. Further discussion took place at senior management level and was reported to the board. Trends were identified both at site level and national level. Feedback occurred in the UCG reflection report and individually to the IPCN if appropriate. The effectiveness of the AMS programme was continually evaluated, and any areas identified for improvement were actioned. Reporting including analysed data was included the monthly quality report through to the board. Staff were informed about antibiotic prescribing and the relationship to the increase of multi drug resistant organisms.</p>

<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>	<p>PA Low</p>	<p>Surveillance was an integral part of the infection prevention and control programme. The purpose and methodology were described in the UCG surveillance policy. The IPCN used the information obtained through surveillance to determine infection prevention activities, resources, and education needs.</p> <p>Monthly infection data was collected for all infections based on standard definitions, however not all required detail was included in data reporting. Infection prevention data was monitored and evaluated monthly and annually. This included monitoring positive results for infections and outbreaks. Trends were identified and analysed, and corrective actions were established where trends were identified. These, along with outcomes and actions were discussed at staff meetings. Meeting minutes were available to all staff. Variances in trends in surveillance data was identified and investigated as verified during interview. Results of surveillance were discussed and reported to clinical governance as required.</p> <p>Whānau were advised if residents developed an infection. Culturally safe communication processes were outlined within the Māori health plan for Māori residents with healthcare associated infections (HAI).</p> <p>Staff were made aware of new infections at handovers on each shift, in the progress notes and in the clinical records. Short term care plans were developed to guide care for residents with an infection. There were processes in place to isolate infectious residents when required.</p> <p>Monthly surveillance data was collected and reported to the executive team, Trends, and opportunities to improve are considered by the IPCN and the national clinical lead. There were no trends identified in IP documents sampled. The reports were discussed at staff meetings, and this was verified by staff.</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</p>	<p>PA Moderate</p>	<p>The facility implemented UCG waste and hazardous management policies that conformed to legislative and local council requirements. Policies included, but were not limited to, considerations of staff orientation and education; incident/accident and hazards reporting; use of PPE; disposal of general, infectious, and hazardous waste.</p>

<p>decisions are made in relation to infection prevention and 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>Current material safety data information sheets were available and accessible to staff in relevant places, such as the laundry and the sluice room. Staff completed a chemical safety training module on orientation.</p> <p>Staff received education on waste management and infection prevention as a component of mandatory training. Yellow containers for sharps and syringes were viewed in clinical areas. The process to manage these was confirmed.</p> <p>Interviews and observations confirmed that there is sufficient PPE and equipment provided, such as aprons, gloves, and masks. Interviews confirmed that the use of PPE is appropriate to the risk. Observation confirmed that PPE was used in high-risk areas.</p> <p>Laundry and cleaning services are provided seven days a week. Rosters sampled confirmed that cleaning and laundry duties are scheduled part time each day with caregivers on afternoon and night shifts, completing any additional laundry tasks required. Visual inspection of the laundry demonstrated that there was a demarcation line between the clean and dirty areas of the laundry. There were two large top loading washing machines being used for all resident linen, clothing and kitchen supplies, these machines have chemicals automatically feeding the machines, however, instructions and monitoring of temperatures needed to wash different types of linen requires improvement. Laundry personnel interviewed demonstrated knowledge of the process to handle and wash infectious items. Clean linen was stored appropriately in hall cupboards with linen trolleys covered when in use. Residents' clothing was labelled and personally delivered from the laundry, as observed. Whānau confirmed satisfaction with laundry services in interviews and satisfaction surveys.</p> <p>Cleaning duties and procedures were documented to ensure correct cleaning processes occur. Cleaning products were dispensed from an in-line system according to the cleaning procedure. There were designated locked cupboards for the safe and hygienic storage of cleaning equipment and chemicals. Chemical bottles/cans in storage and in use were noted to be appropriately labelled.</p> <p>There was a policy to provide direction and guidance to safely reduce the risk of infection during construction, renovation, installation, and maintenance activities. The policy details consultation by the infection</p>
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		control team. There was no construction, installation, or maintenance in progress at the time of the audit.
<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>Policies, procedures, and processes were 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 was managed through an established process consistently across all Ultimate Care Group facilities. The UCG clinical lead was responsible for restraint practices throughout UCG facilities. The CSM was the restraint coordinator at Lakewood.</p> <p>If restraint were to be considered, the decision-making escalation process required input from the national restraint team. Staff interviews confirmed the organisations approach to the elimination of restraint and management of behavioural challenges through alternative means. Falls risks were highlighted as part of this approach and outcomes considered along with other alternatives. The safety of residents and staff was always considered by the restraint team, and this was discussed.</p> <p>Records confirmed the completion of restraint minimisation and safe restraint use training with annual updates completed. Staff reported they were trained and competent to manage challenging behaviour, documentation confirmed this.</p> <p>Staff interviewed confirmed the processes that were 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, there were processes in place to ensure Māori/whānau oversight is provided.</p> <p>Executive leaders received restraint reports monthly alongside aggregated restraint data, including the type and frequency of restraint if restraint had occurred. This formed part of the regular reflection report to the board.</p> <p>There were no episodes of restraint recorded since the last audit. Restraint would only be considered as a last resort.</p>

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 1.5.3</p> <p>My property shall be respected, and my finances protected within the scope of the service being provided.</p>	PA Moderate	Discussion with staff and resident records sampled evidenced that not all resident admission agreements had been transferred to UCG.	Four out of six resident admission agreements sampled evidenced that the agreement was with the previous owner of Lakewood and had not been transferred to UCG.	<p>Ensure all Lakewood resident agreements are completed using UCG documentation.</p> <p>90 days</p>
<p>Criterion 5.2.2</p> <p>Service providers shall have a clearly defined and documented IP programme that shall be:</p> <p>(a) Developed by those with IP expertise;</p> <p>(b) Approved by the governance body;</p> <p>(c) Linked to the quality</p>	PA Low	The infection prevention and control nurse has had training for her role, however, there was no documented annual infection prevention and control programme in place.	There is no documented infection prevention and control programme being used to guide infection prevention and control activities.	<p>Ensure that a clearly defined and documented infection prevention and control programme is used to guide infection prevention activities and that it is reviewed annually.</p> <p>180 days</p>

improvement programme; and (d) Reviewed and reported on annually.				
<p>Criterion 5.4.3</p> <p>Surveillance methods, tools, documentation, analysis, and assignment of responsibilities shall be described and documented using standardised surveillance definitions. Surveillance includes ethnicity data.</p>	PA Low	Surveillance reports documented the residents name, national health index (NHI) number and other relevant data, however the resident's ethnicity was not included on the report.	Surveillance reports do not include the resident's ethnicity.	<p>Ensure surveillance reports include the resident's ethnicity.</p> <p>180 days</p>
<p>Criterion 5.5.4</p> <p>Service providers shall ensure there are safe and effective laundry services appropriate to the size and scope of the health and disability service that include:</p> <p>(a) Methods, frequency, and materials used for laundry processes;</p> <p>(b) Laundry processes being monitored for effectiveness;</p> <p>(c) A clear separation between handling and storage of clean and dirty laundry;</p> <p>(d) Access to designated areas for the safe and hygienic storage of laundry equipment and chemicals. This shall be reflected in a written policy.</p>	PA Moderate	There was a demarcation line between the clean and dirty areas of the laundry, however there were no instructions for staff as to what temperature to use for each type of laundry processed in the two large top loading washing machines. The machines have dials on them for hot, warm, and cold wash. Chemicals are fed into the machines automatically. The temperature of the hot water going into the machine is monitored by Ecolab monthly and varies between 60 and 63 degrees. It appeared that most items except for the kitchen loads are processed on a warm cycle which may or may not be sufficient to reduce bacterial contamination with the input of chemicals, but there is no monitoring of effectiveness to confirm this or to confirm that processing of the laundry meets best practice. There are no documented instructions for staff as to what temperature to use for each type of	There are insufficient written instructions for staff processing different types of laundry. It is unclear what temperature laundry is being processed at and no monitoring of the effectiveness of laundry processing occurs.	<p>Ensure that laundry processes meet best practice.</p> <p>90 days</p>

		laundry processed.		
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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, there 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.