The Ultimate Care Group Limited - Ultimate Care Ranburn

Introduction

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

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

The abbreviations used in this report are the same as those specified in section 0.4 of the Ngā Paerewa Health and Disability Services Standard (NZS8134:2021).

You can view a full copy of the standard on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	The Ultimate Care Group Limited
Premises audited:	Ultimate Care Ranburn
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: 25 May 2022 End date: 26 May 2022

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: 64

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six sections contained within the Ngā Paerewa Health and Disability Services Standard:

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

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

Key to the indicators

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

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

General overview of the audit

Ultimate Care Ranburn is part of the Ultimate Care Group Limited. It is certified to provide services for up to 71 people requiring rest home (inclusive of secure dementia care) or hospital level services. The facility is managed by a facility manager and a clinical nurse services manager. Occupancy on the first day of this audit was 64 residents. There have been no significant changes to services at the facility since the last audit.

This certification audit was conducted against the Health and Disability Services Standards Nga Paerewa NZS8134:2021 and the service contracts with the district health board.

The audit process included review of policies and procedures, review of resident and staff files, observations and interviews with family, residents, governance, management, staff and a general practitioner.

Areas identified as requiring improvement relate to: quality management systems, staffing, training, staff appraisals, care planning (inclusive of cultural assessment, family input and interventions), activities, evaluation, food service, medication management (storage and administration), safe environment, restraint and accident and incident documentation.

Ō tatou motika | Our rights

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

The service complies with the Code of Health and Disability Consumers' Rights. Residents receive services in a manner that considers their dignity, privacy, and independence and facilitates informed choice and informed consent.

Staff receive training in Te Tiriti o Waitangi and cultural safety which is reflected in service delivery. Care is provided in a way that focuses on the individual and takes into account values, beliefs, culture, religion, sexual orientation and relationship status.

Policies are implemented to support residents' rights, communication, complaints management and protection from abuse. The service has policy in place regarding open disclosure which is applied. Complaints processes are implemented.

Care plans accommodate the choices of residents and/or their family/whānau.

Hunga mahi me te hanganga | Workforce and structure

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

Ultimate Care Group Limited is the governing body responsible for the services provided at this facility. The organisation's mission statement and vision are documented and displayed in the facility. The service has a current business plan and quality and risk management plan in place.

The governance body has an understanding of the obligation to comply with Nga Paerewa NZS8134:2021

An experienced and suitably qualified facility manager ensures the management of the facility. A clinical services manager oversees the clinical and care services in the facility. A regional manager supports the facility's managers in their roles.

The quality and risk management systems are in place. Meetings are held that include reporting on various clinical indicators, quality and risk issues, and there is discussion of identified trends.

There are human resource policies and procedures to guide practice in relation to recruitment, and orientation and management of staff, that are based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance review.

Systems are in place to ensure the secure management of resident and staff data.

Ngā huarahi ki te oranga | Pathways to wellbeing

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

On entry to the service information is provided to residents and their whanau and consultation occurs regarding entry criteria and service provision. Information is provided in accessible formats as required.

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

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

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

Handovers between shifts guide continuity of care and teamwork is encouraged.

There are policies and processes that describe medication management that align with accepted guidelines. Staff responsible for medication administration have completed annual competencies and education.

The activity programme is managed by a diversional therapist. The activity team provides an activities programme in the rest home and hospital and a separate programme in the dementia care unit. The programme provides residents with a variety of individual and group activities and maintains their links with the community.

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

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

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

There is a current building warrant of fitness. A reactive and preventative maintenance programme is implemented. External areas are accessible, safe and provide shade and seating.

Residents' bedrooms are of an appropriate size for the safe use and manoeuvring of mobility aids if required and allow for care to be provided. Lounges, dining rooms and sitting alcoves are available for residents and their visitors. Communal and individual spaces are maintained at a comfortable temperature.

A call bell system is available to allow residents to access help when needed. Security systems are in place and staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored.

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

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

The infection prevention and antimicrobial stewardship programmes are appropriate to the size and complexity of the service and include policies and procedures to guide staff.

A registered nurse is the infection control nurse. Infection data is collated, analysed, and trended. Antimicrobial prescribing is monitored. Monthly surveillance data is reported to staff.

There have been two outbreaks since the previous audit. There are organisational Covid-19 prevention strategies in place.

Here taratahi | Restraint and seclusion

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

The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint. Staff receive training around restraint minimisation and the management of challenging behaviour. Restraint is overseen by the restraint co-ordinator who is a registered nurse. No approved restraints are being used at Ranburn.

Summary of attainment

The following table summarises the number of subsections and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Subsection	0	18	0	6	4	0	0
Criteria	0	158	0	7	5	0	0

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

Attainment against the Ngā Paerewa Health and Disability Services Standard

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

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

For more information on the standard, please click here.

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

Subsection with desired outcome	Attainment Rating	Audit Evidence
Subsection 1.1: Pae ora healthy futures Te Tiriti: Māori flourish and thrive in an environment that enables good health and wellbeing. As service providers: We work collaboratively to embrace, support, and encourage a Māori worldview of health and provide high-quality, equitable, and effective services for Māori framed by Te Tiriti o Waitangi.	FA	Staff receive training in cultural safety at orientation. The service has developed and implemented a cultural safety module that is provided as part orientation and of the mandatory two-yearly education programme. It defines and explains cultural safety and its importance; Te Tiriti o Waitangi; and tikanga best practice. All staff have completed this. At the time of the audit there were three residents who identified as Māori. Residents and their family/whānau are encouraged to participate in the development of the resident's care plan. Opportunities for input into services are provided through residents' meetings. The organisation has a Māori health action plan that states that the recruitment and training of Māori staff will be encouraged and there is one staff employed who identify as Māori. The plan also identifies that Ultimate Care Group Limited (UCG) aims to improve outcomes for Māori. Strategies include but are not limited to: setting out priority

		areas; supporting the role of Mātauranga Māori in the development and delivery of health services; promoting a collective action (by government communities and social sectors) in working towards pae ora, and that all residents identifying as Māori will be offered the opportunity to have iwi/hapū and/or whanau representation contacted and present. However, the plan is not fully implemented.
Subsection 1.2: Ola manuia of Pacific peoples in Aotearoa The people: Pacific peoples in Aotearoa are entitled to live and enjoy good health and wellbeing. Te Tiriti: Pacific peoples acknowledge the mana whenua of Aotearoa as tuakana and commit to supporting them to achieve tino rangatiratanga. As service providers: We provide comprehensive and equitable health and disability services underpinned by Pacific worldviews and developed in collaboration with Pacific peoples for improved health outcomes.	Not Applicable	There is a cultural safety policy that describes the procedure for identifying and meeting cultural needs, as well as physical, spiritual and psychological needs. It includes culturally sensitive considerations and practices. However, the policy does not identify or address the cultural needs of Pacific peoples. Family/whānau interviews stated that they were satisfied with the choices they were provided regarding their care, activities and the services provided. Information gathered during assessments includes identifying a resident's specific cultural needs, spiritual values, and beliefs. Assessments also include obtaining background information on a resident's cultural preferences, which includes, but is not limited to: beliefs; cultural identity; and spirituality. This information informs care planning and activities that are tailored to meet identified needs and preferences. The cultural safety policy includes consideration of spiritual needs in care planning.
Subsection 1.3: My rights during service delivery The People: My rights have meaningful effect through the actions and behaviours of others. Te Tiriti:Service providers recognise Māori mana motuhake (self-determination). As service providers: We provide services and support to people in a way that upholds their rights and complies with legal requirements.	FA	The service has implemented policies and procedures to ensure that services are provided in a manner that is consistent with the Health and Disability Commission Code of Health and Disability Services Consumers' Rights (the Code). All staff have received education on the Code as part of orientation and the mandatory two-yearly education programme. Staff interviews confirmed awareness of the Code and observations evidence practices that demonstrate an understanding of their obligations. Evidence that the Code is implemented in their everyday practice includes but is not limited to: maintaining residents' privacy; providing residents with choice; and providing opportunities family/whānau and

		residents to be involved in resident case conferences. Residents and their families are provided with information about the Code as part of an information pack and booklet provided on admission to Ultimate Care (UC) Ranburn. The booklet and admission agreement includes information on the complaints process and the advocacy service. The FM and the clinical services manager (CSM) explain the Code during the admission process to ensure understanding. Posters in te reo Māori and English and brochures were visible throughout the facility. There is an advocacy policy for staff to follow to ensure the Code is upheld and residents have access to representation. It includes facilitating access to advocacy for a resident if required. This information is displayed at the facility entrance. Policy and practice include ensuring that all residents, including Māori residents', right to self-determination is upheld and they are able to practice their own personal values and beliefs. The Māori health plan identifies how UCG will respond to Māori cultural needs and beliefs in relation to illness.
Subsection 1.4: I am treated with respect The People: I can be who I am when I am treated with dignity and respect. Te Tiriti: Service providers commit to Māori mana motuhake. As service providers: We provide services and support to people in a way that is inclusive and respects their identity and their experiences.	FA	The provider has policies to ensure that residents and whānau are included in planning and care. However, these are not consistently applied, (refer to 3.2.1). Care planning is inclusive of discussion and choices in regard to maintaining independence and the level of interdependence required. Staff and family/whānau interviews and observation confirmed that individual, religious, social preferences, values and beliefs are identified, and upheld. These were also documented in resident files, with the exception of cultural needs (refer to 3.2.3). The organisation has a policy on sexuality and intimacy that provides guidelines for managing expressions of sexuality. Staff interviews confirmed that they assist residents to choose the clothing they wish to wear. Resident and family/whānau interviews and observation confirmed that residents can choose what clothing and adornments to

		wear each day, including makeup, if that is their preference. The organisation has policies and procedures that are aligned to the requirements of the Privacy Act and Health Information Privacy Code, to ensure that a resident's right to privacy and dignity is upheld. They provide guidelines for respecting and maintaining privacy and dignity. There are spaces where residents can find privacy within communal areas. Resident, family/whānau and staff interviews, and observation confirmed that: staff knock on bedroom and bathroom doors prior to entering; ensure that doors are shut when personal cares are being provided and residents are suitably attired when taken to the bathroom. Interviews and observation confirmed that staff maintain confidentiality and are discrete, holding conversations of a personal nature in private. Residents' interviews confirmed that resident privacy is respected. Staff receive training in tikanga best practice. Culturally appropriate activities have been introduced such as celebrating Waitangi Day and Matariki. Interviews with staff confirmed their understanding of the cultural needs of Māori, including in death and dying as well as the importance of involving family/whānau in the delivery of care. There is one staff member available to speak in te reo Māori if this is a resident's wish.
Subsection 1.5: I am protected from abuse The People: I feel safe and protected from abuse. Te Tiriti: Service providers provide culturally and clinically safe services for Māori, so they feel safe and are protected from abuse. As service providers: We ensure the people using our services are safe and protected from abuse.	FA	The admission agreement, signed prior to occupation, provides clear expectations regarding the management and responsibilities of personal property and finances. Residents and/or their family/whānau provide consent for the facility to manage the resident's comfort funds. There was no evidence of abuse of residents' property or possessions. There is policy that defines guidelines and the responsibilities of staff, for reporting suspected abuse. It includes definitions of abuse and guidelines for managing abuse. Staff receive orientation and mandatory annual training on abuse and neglect. Staff interviews confirmed staff awareness of their obligations to report any incidences

		of suspected abuse or neglect. Staff, general practitioner (GP) and family/whānau interviews confirmed that there was no evidence of abuse or neglect. There were no documented incidents of abuse or neglect. There are policies and processes to ensure that the environment for residents is free from discrimination; coercion; harassment; and financial exploitation. They provide guidance for staff on how this will be prevented and, where suspected, reported. There were no documented complaints or incidents recorded since the previous audit relating to any form of discrimination, coercion, or harassment. Job descriptions include the responsibilities of the position, including ethical issues relevant to each role. Staff interviews confirmed awareness of their obligation to report any evidence of discrimination, abuse and neglect, harassment, and exploitation. Staff are required to sign and abide by the UCG code of conduct and professional boundaries agreement. All staff files reviewed evidenced these were signed. Staff mandatory training includes professional boundaries. Staff interviews confirmed their understanding of professional boundaries relevant to their respective roles. Interviews with residents and families/whānau confirmed that professional boundaries are maintained by staff. Resident interviews described that the service promotes an environment in which residents and their families/whānau feel safe and comfortable to raise any questions or queries, and that discussions are free and frank.
Subsection 1.6: Effective communication occurs The people: I feel listened to and that what I say is valued, and I feel that all information exchanged contributes to enhancing my wellbeing. Te Tiriti: Services are easy to access and navigate and give clear	FA	There is policy to ensure that residents and their family/whānau have the right to comprehensive information, supplied in a way that is appropriate for the resident and/or their family/whānau and takes account of specific language requirements and any disabilities. An interview with the FM confirmed that where required interpreters and cultural representatives/advocacy services are accessed to ensure information is understood. Staff represent several ethnicities and can communicate with residents in their native dialect if the resident

and relevant health messages to Māori. As service providers: We listen and respect the voices of the people who use our services and effectively communicate with them about their choices.		wishes. At the time of the audit there were no residents who required an interpreter. There is policy requiring that family/whānau are advised within 24 hours of an event occurring and this is implemented. Monthly resident meetings inform residents and families of facility activities. Family/whānau are welcome to attend meetings. Meetings are advertised in the activities planner, and newsletter. Meetings follow a set agenda and are chaired by the local advocate. Meeting minutes, interviews and observation demonstrate attendance by residents and family/whānau. Resident meetings also offer an opportunity to provide feedback and make suggestions for improvement as well as raise and discuss issues/concerns with management. Copies of the activities plan, and menu are available to residents and families. Resident and family/whānau interviews confirmed that staff are approachable and available to discuss queries and issues. The resident admission agreement signed by the resident or enduring power of attorney (EPOA), confirms for residents, what is and what is not included in service provision.
Subsection 1.7: I am informed and able to make choices The people: I know I will be asked for my views. My choices will be respected when making decisions about my wellbeing. If my choices cannot be upheld, I will be provided with information that supports me to understand why. Te Tiriti: High-quality services are provided that are easy to access and navigate. Providers give clear and relevant messages so that individuals and whānau can effectively manage their own health, keep well, and live well. As service providers: We provide people using our services or their legal representatives with the information necessary to make	FA	There is an informed consent policy to ensure that a resident who has the capacity/competence to consent to a treatment or procedure, has been given sufficient information to enable that resident to arrive at a reasoned and voluntary decision. It provides guidelines for staff to ensure adherence to the legal and ethical requirements of informed consent and informed choice. The policy includes a definition of consent and procedures and how this will be facilitated and obtained. Staff receive orientation and training on informed consent and all staff interviewed, including non-clinical staff, demonstrated that they are cognizant of the procedures to uphold informed consent. The information pack includes information regarding informed consent. The FM or CSM discuss and explain informed consent to residents and whānau during the

informed decisions in accordance with their rights and their ability to exercise independence, choice, and control.		admission process to ensure understanding. This includes consent for resuscitation and advance directives. There is a resuscitation order and advance directives policy to ensure that the rights of the resident are respected and upheld, and residents are treated with dignity during all stages of serious illness. The policy defines the procedure for obtaining an advance directive and who may or may not make an advance directive. Verbal consent is expected for activities of daily living; and specific consent is sought for: end of life care; advance care planning; and a note recorded for resuscitation decision. Informed consent of the resident and/or EPOA is documented. It includes consent to the release of medical information; medical review by other health professionals, medication administration, blood tests; vaccinations; consent to students; photographs on files and recreational activities. Residents sign a separate consent for media such as posts on the facility's notice board and newsletter. File reviews demonstrated that advance directives and resuscitation orders are completed in accordance with policy. When required advance care planning and EPOAs were initiated and documented. The informed consent policy acknowledges Te Tiriti and the impact of culture and identity on the determinants of the health and well-being of Māori residents. It requires health professionals to recognise these factors as relevant when issues of consent to health care of Māori residents arise. This includes whānau support and involvements in the decision-making, care and treatment of the resident, provided the resident has given consent for the whānau to be involved.
Subsection 1.8: I have the right to complain The people: I feel it is easy to make a complaint. When I complain I am taken seriously and receive a timely response. Te Tiriti: Māori and whānau are at the centre of the health and disability system, as active partners in improving the system and	FA	The organisation has a complaints policy and process to manage complaints that is in line with Right 10 of the Code. The complaint process is made available in the admission agreement and explained by the FM or CSM on the resident's admission. The complaint forms and a complaint box are also available in resident areas in the facility. The FM is responsible for managing complaints. There had been five

their care and support. As service providers: We have a fair, transparent, and equitable system in place to easily receive and resolve or escalate complaints in a manner that leads to quality improvement.		complaints over 2021/22. A complaints register is in place that includes the name of the complainant; date the complaint is received; the date the complaint was responded to; and the date of the resolution as well as the date the complaint is signed off. Evidence relating to the complaint is held in the complaints folder and register. Interview with the FM and a review of complaints indicated that complaints are investigated promptly, and issues are resolved in a timely manner. Interviews with the FM, staff and residents confirmed that residents are able to raise any concerns and provide feedback on services and this includes discussing and explaining the complaints process. Resident and family/whānau interviews confirmed that they are aware of the complaints process. Residents and family/whānau stated that they had been able to raise any issues directly with the FM or CSM. The UCG national support office provides advise and support and complaints are monitored.
Subsection 2.1: Governance The people: I trust the people governing the service to have the knowledge, integrity, and ability to empower the communities they serve. Te Tiriti: Honouring Te Tiriti, Māori participate in governance in partnership, experiencing meaningful inclusion on all governance bodies and having substantive input into organisational operational policies. As service providers: Our governance body is accountable for delivering a highquality service that is responsive, inclusive, and sensitive to the cultural diversity of communities we serve.	FA	The Ultimate Care Ranburn facility is part of Ultimate Care Group (UCG) with the executive team providing direction to the service. The UCG governance body meets legislative, contractual, and regulatory requirements with commitment to international conventions ratified by the New Zealand government. The UCG governance body understands the obligation to comply with Nga Paerewa NZS8134:2021 as confirmed at interview with the chief executive officer (CEO). The annual strategic, business plan, has key outcomes which are resident centred, such as; resident satisfaction; health and safety; complaints; education and fiscal stability; and are monitored at board meetings. There is Māori representation at governance level. The CEO described the core competencies that executive management are required to demonstrate, and these include understanding of the services' obligations under Te Tiriti, health equity, and cultural safety. The organisation has a documented strategic plan incorporating vision, mission, and values statements. The organisation values were

		displayed in the facility and in information available to residents and family/whānau. The facility Māori health plan describes how the organisation will ensure equity. The FM described how the facility is introducing the basics of te reo Māori and supports staff to upskill in Māori Tikanga. Families/whānau are encouraged to participate in the planning, implementation, monitoring, and evaluation of service delivery. The UCG management team has a clinical governance structure in place (for example the appointment of a clinical head of resident risk) that is appropriate to the size and complexity of the service provision. The clinical operations management group report to the board monthly on the key aspects noted above. The management team has also recently appointed a project manager to support the implementation of the Nga Paerewa standards. The FM reports to a regional manager (RM) who oversees the facility's quality and operational performance. The RM holds meetings with all FMs and the clinical service managers (CSM) in the region and visits the facility in person at least three-monthly, in addition to providing ongoing remote support. The RM provided on-site support to the facility during this audit. The FM has been in the role for seven months and is a RN manager with a current annual practicing certificate and have qualifications in mental health and education. The CSM has held this position for three months and is a RN with a current annual practicing certificate. with previous experience in aged community care. Both managers have completed at least eight hours educational training and UCG management orientation programs. In the absence of the CSM a RN covers the role for short periods. For longer periods the RM would appoint a temporary CSM. In the absence of the facility manager the CSM steps into the role. The service provides rest home, dementia and hospital level care for up to 71 residents. These beds are made up of – 26 rest home only beds, 21 hospital only beds, 6 dual purpose beds and 18 dementia

		beds. At the time of the audit, there were a total of 64 residents, of these there were: 24 residents receiving hospital level care; 29 residents receiving rest home level care, and 18 residents within the secure dementia wing. Included in these numbers was one resident on respite care. At the time of audit all residents were under the district health board (DHB) aged related residential care (ARRC) agreement. There are no residents with an occupation rights agreement.
Subsection 2.2: Quality and risk The people: I trust there are systems in place that keep me safe, are responsive, and are focused on improving my experience and outcomes of care. Te Tiriti: Service providers allocate appropriate resources to specifically address continuous quality improvement with a focus on achieving Māori health equity. As service providers: We have effective and organisation-wide governance systems in place relating to continuous quality improvement that take a risk-based approach, and these systems meet the needs of people using the services and our health care and support workers.	PA Low	The organisation has an annually reviewed, executive team approved quality and risk management plan, that is developed with input from facility staff. The plan outlines the quality and risk management framework to promote continuous quality improvement. There are policies and procedures, and associated systems to ensure that the facility meets accepted good practice and adheres to relevant standards, including standards relating to the Health and Disability Services (Safety) Act 2001. There is an implemented annual schedule of internal audits. Areas of non-compliance from the internal audits include the implementation of a corrective action plan with sign-off by the FM when completed. However, analysis of trends and evaluation of outcomes requires improvement. Since the last audit, a new reporting tool called the ‘manager’s reflective report’ has been developed and enacted to capture quality improvement initiatives as a result of internal audit findings. Quality improvement initiatives include care planning, medication management, progress note writing and incident and accident reporting, as well as refurbishment of the facility. Ultimate Care Ranburn has appointed a health and safety team with representatives from all areas, who are supported by facility manager. The facility holds a comprehensive monthly meeting for all staff, that

		include; quality, health and safety, staff, caregivers, RNs and infection control and prevention with good staff attendance. Meetings minutes evidence that a comprehensive range of subjects are discussed. At interview, through observation and resident meetings it was noted that residents were able to be involved in decision making/choices as well as access to technical aids and technology within the service. Completed hazard identification forms and staff interviews show that hazards are identified. The hazard register sighted is relevant to the service and has been regularly reviewed and updated. The facility follows the UCG national adverse event reporting policy for internal and external reporting (where required) to reduce preventable harm by supporting system improvement. Notifications to HealthCERT under Section 31 were noted for the appointment of the FM, and the CSM, and there has been ongoing reporting regarding the lack of RN cover for shifts throughout 2021-22, which is now required to have fortnightly reports to the DHB. High quality health care and equality for Māori is clearly stated within the Māori Health Plan and policy.
Subsection 2.3: Service management The people: Skilled, caring health care and support workers listen to me, provide personalised care, and treat me as a whole person. Te Tiriti: The delivery of high-quality health care that is culturally responsive to the needs and aspirations of Māori is achieved through the use of health equity and quality improvement tools. As service providers: We ensure our day-to-day operation is managed to deliver effective person-centred and whānau-centred services.	PA Moderate	Ultimate Care Ranburn policy includes the rationale for staff rostering and skill mix, inclusive of a facility manager's roster allocation tool to ensure staffing levels are maintained at a safe level. Interviews with residents, relatives and staff confirmed that staffing levels are sufficient to meet the needs of residents when there is full staff available. Rosters reviewed evidenced that staff were replaced when sick by other staff members picking up extra shifts and with some shifts left short. Laundry and cleaning staff are rostered on seven days per week. The FM works 40 hours per week, Monday to Friday, and is available on call for any non-clinical emergency issues. The CSM works 40 hours per week and is available on call for clinical support and as well,

		staff are supported by the Ultimate Care on-call clinical support helpline. Due to staff turnover and leave taken, the facility does not have full 24/7 RN cover for all shifts The FM with the assistance of head office human resources staff is currently advertising and recruiting for vacant positions, as well as in local newspapers. Two RNs (inclusive of the CSM) are interRAI trained and caregivers complete Careerforce training in New Zealand Qualification Standards (NZQA) to level four. There is an implemented annual training programme. Staff competencies and education scheduled are relevant to the needs of aged-care residents, including those receiving hospital non acute medical cares. An annual resident and relative satisfaction survey was completed in 2021, with an average rating of 93% approval. An area highlighted as requiring corrective action related to the housekeeping. Corrective action plans were initiated, and two cleaners are now employed at the facility. Support systems promote health care and support worker wellbeing, and a positive work environment was confirmed in staff interviews. Employee support services are available as required, as well as support for staff and whānau during covid-19 lockdowns. The service collects both staff and resident ethnicity to inform data regarding Māori health information.
Subsection 2.4: Health care and support workers The people: People providing my support have knowledge, skills, values, and attitudes that align with my needs. A diverse mix of people in adequate numbers meet my needs. Te Tiriti: Service providers actively recruit and retain a Māori	PA Low	Human resource management follow policies and processes which adhere to the principles of good employment practice and the Employment Relations Act 2000. Review of staff records confirmed the organisation's policy is consistently implemented and records are maintained. The recruitment processes include: police vetting; reference checks

health workforce and invest in building and maintaining their capacity and capability to deliver health care that meets the needs of Māori. As service providers: We have sufficient health care and support workers who are skilled and qualified to provide clinically and culturally safe, respectful, quality care and services.		and a signed agreement with a job description. Current practicing certificates were sighted for all staff and contractors who require these to practice. Personnel involved in driving the van held current driver licences and first aid certificates. Non-clinical staff include household and laundry personnel, a part time maintenance person, a part-time gardener, and kitchen staff. There is a documented and implemented orientation programme and staff training records show that training is attended. There was recorded evidence of staff receiving an orientation, with a generic component specific to their roles, on induction. Staff interviews confirmed completing this and stated that it was appropriate to their role. Three-monthly reviews had been carried out for newly appointed staff, however annual performance appraisals were not completed for all staff requiring these. Staff competencies and scheduled education are relevant to the needs of aged-care residents, including those receiving hospital level cares. Two RNs (inclusive of the CSM) are interRAI trained and caregivers complete Careerforce training in New Zealand Qualification Standards (NZQA) to level four. Records reviewed showed that ethnicity data is collected, recorded, and used in accordance with Health Information Standards Organisation (HISO) requirements.
Subsection 2.5: Information The people: Service providers manage my information sensitively and in accordance with my wishes. Te Tiriti: Service providers collect, store, and use quality ethnicity	FA	Residents' records and medication charts are managed electronically. Residents' information, including progress notes, is entered into the resident's record in an accurate and timely manner. The name and designation of the person making the entry is identifiable. Residents' progress notes are completed every shift, detailing residents' response to service provision.

data in order to achieve Māori health equity. As service provider: We ensure the collection, storage, and use of personal and health information of people using our services is accurate, sufficient, secure, accessible, and confidential.		There are policies and procedures in place to ensure the privacy and confidentiality of resident information. Staff interviews confirmed an awareness of their obligations to maintain the confidentiality of resident information. Resident care and support information can be accessed in a timely manner and is protected from unauthorised access. Electronic password protection and any hard copy information is locked away when not in use. Documentation containing sensitive resident information is not displayed in a way that could be viewed by other residents or members of the public. Each residents' whānau and resident information is maintained in an individual, uniquely identifiable record. Records include information obtained on admission, with input from the residents' family where applicable. The clinical records are integrated, including information such as medical notes, assessment information and reports from other health professionals. National Health Index registrations of people receiving services meet the recording requirements specified by the Ministry of Health.
Subsection 3.1: Entry and declining entry The people: Service providers clearly communicate access, timeframes, and costs of accessing services, so that I can choose the most appropriate service provider to meet my needs. Te Tiriti: Service providers work proactively to eliminate inequities between Māori and non-Māori by ensuring fair access to quality care. As service providers: When people enter our service, we adopt a person-centred and whānau-centred approach to their care. We focus on their needs and goals and encourage input from whānau. Where we are unable to meet these needs, adequate information about the reasons for this decision is documented and	FA	On enquiry, an information booklet detailing entry criteria is provided to prospective residents and their family/whānau. This information is also available on the internet. There is a resident admission policy that defines the screening and selection process for admission. Review of residents' files confirmed that entry to service complied with entry criteria. The service has a process in place if access is declined, should this occur. It requires that when residents are declined access to the service, residents and their family/whānau, the referring agency, GP and/or nurse practitioner (NP) are informed of the decline to entry. Alternative services when possible are to be offered and documentation of reason in internal files. The resident would be

communicated to the person and whānau.		declined entry if not within the scope of the service or if a bed was not available. The Needs Assessment and Service Coordination (NASC) assessments are completed for entry to the service. All resident files reviewed had current interRAI assessments in place. The admission policy requires the collection of information that includes but is not limited to: ethnicity; spoken language; interpreter requirements; iwi; hapū; religion; and referring agency. Interviews with residents and families and review of records confirmed the admission process was completed in a timely manner. Ethnicity, including Māori, is being collected and analysed by the service. The FM described relationships with identified Māori service provider groups within the community.
Subsection 3.2: My pathway to wellbeing The people: I work together with my service providers so they know what matters to me, and we can decide what best supports my wellbeing. Te Tiriti: Service providers work in partnership with Māori and whānau, and support their aspirations, mana motuhake, and whānau rangatiratanga. As service providers: We work in partnership with people and whānau to support wellbeing.	PA Moderate	RNs are responsible for all residents' assessments, care planning and evaluation of care. Resident care plans are developed using an electronic system. Initial care plans are developed with the resident's/EPOA consent within the required timeframe. They are based on data collected during the initial nursing assessments, which includes dietary needs; pressure injury; falls risk and social history and information from pre-entry assessments completed by the NASC or other referral agencies. The individualised long term care plans (LTCPs) are developed with information gathered during the initial assessments and the interRAI assessment and completed within three weeks of the residents' admission to the facility. Review of LTCPs identified that overall, these were resident-centred and included medical information, activities of daily living, categories of care with support needs and interventions to meet the resident goals, However, documentation of family/whānau input into assessments and the development and review of LTCPs requires improvement.

		Short-term care plans (STCPs) are developed for the management of acute problems. All resident files contained a signed informed consent form. Resident care plans are developed using an electronic system. The electronic system allows for recording of early warning signs and risks however, these are not recorded in sufficient detail. The residents' activities assessments are completed by the diversional therapist (DT) in conjunction with the RN within three weeks of the residents' admission to the facility. Information on residents' interests, family and previous occupations is gathered during the interview with the resident and/or their family/whanau and documented. The residents' activity needs are reviewed six monthly at the same time as the care plans. The activity assessment includes a cultural assessment which is designed to gather information about cultural needs, values, and beliefs, however these require improvement. The initial medical assessment is undertaken by GP within the required timeframe following admission. Residents have reviews by the GP within required timeframes and when their health status changes. There is documented evidence of the exemption from monthly GP visits when the resident's condition is considered stable. Contact details for family are recorded on the electronic system, interviews with family/whānau and resident records evidenced that family are informed where there is a change in health status. The GP visits the facility twice weekly. Documentation and records reviewed were current. The GP interviewed stated that there was good communication with the service and that they were informed of concerns in a timely manner. The facility has access to an after-hours service. A physiotherapist visits the facility weekly and reviews residents referred by the CSM or RNs. There was evidence of wound care products available at the facility.

		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. Policies and protocols are in place to ensure continuity of service delivery. Staff interviews confirmed they are familiar with the needs of all residents in the facility and that they have access to the supplies and products they require to meet those needs. Staff receive handover at the beginning of their shift, this is managed using the electronic system with additional input from the RN as required. The nursing progress notes are recorded and maintained. Monthly observations such as weight and blood pressure were completed and are up to date. Resident care is evaluated on each shift and reported at handover and in the progress notes. If any change is noted, it is reported to the RN. Long term care plans are formally evaluated every six months in conjunction with the interRAI re-assessments and if there is a change in the resident's condition. Evaluations are documented by the RN. The evaluations include the degree of achievement towards meeting desired goals and outcomes. There is policy that details the required steps to be taken following a resident fall. However, this is not consistently implemented. Residents interviewed confirmed assessments are completed according to their needs and in the privacy of their bedrooms. The Māori care plan, which is part of the electronic system, is to be used for residents who identifies as Māori and assists Māori residents to identify their own Pae Ora outcomes. However, this requires improvement.
Subsection 3.3: Individualised activities	PA Low	The residents' activities programme is implemented by a DT and two activity assistants. Activities for the residents in the hospital and rest home are provided Monday to Friday 09.15am to 3.30pm. At

The people: I participate in what matters to me in a way that I like. Te Tiriti: Service providers support Māori community initiatives and activities that promote whanaungatanga. As service providers: We support the people using our services to maintain and develop their interests and participate in meaningful community and social activities, planned and unplanned, which are suitable for their age and stage and are satisfying to them.		weekends puzzles, quizzes and movies are available for residents. The activities programme is displayed in the communal area and on the individual resident noticeboards. The activities programme provides variety in the content and includes a range of activities which incorporate education, leisure, cultural, spiritual and community events. For those residents who choose not to take part in the programme, one on one visits from the DTs occur regularly. A café outing is organised weekly and regular van outings into the community are arranged. Church services are held weekly. The programme has included Te Reo week, visits from the Kapa Haka group from the local primary school, flax weaving and Matariki celebrations. Other cultural activities that have been held include armchair travel to Japan, Poland and India and a Scottish country dancing display. Family/whānau participation in the programme is encouraged. The residents and their families reported satisfaction with the activities provided. Over the course of the audit residents were observed engaging and enjoying a variety of activities. In the secure dementia unit activities are provided Monday to Friday 7.30am to 3pm. Residents living in the dementia wing have assessments on admission relating to their previous life experiences, interests, and pastoral care needs. The activity section of the long-term care plan is developed from these assessments; however, this area requires improvement. Additional nutritious snacks are available in the secure dementia unit over a 24-hour period.
Subsection 3.4: My medication The people: I receive my medication and blood products in a safe and timely manner. Te Tiriti: Service providers shall support and advocate for Māori to	PA Moderate	A current medication management policy identifies all aspects of medicine management in line with relevant legislation and guidelines. A safe system for medicine management using an electronic system was observed on the day of audit. Prescribing practices are in line with legislation, protocols, and guidelines. The required three-monthly reviews by the GP were recorded electronically. Resident allergies

access appropriate medication and blood products. As service providers: We ensure people receive their medication and blood products in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.		and sensitivities are documented on the electronic medication chart and in the resident's electronic record. The service uses pharmacy pre-packaged medicines that are checked by the RN on delivery to the facility. All stock medications sighted were within current use by dates. A system is in place for returning expired or unwanted medication to the contracted pharmacy. Medication room temperatures are not recorded as per UCG policy, and whilst the medication refrigerator temperatures are monitored daily these temperatures have been outside the required range with no corrective action initiated. Medications are stored securely in accordance with requirements. Medications are checked by two staff for accuracy in administration. Weekly checks of medications and six monthly stocktakes are conducted in line with policy and legislation. The staff observed administering medication demonstrated knowledge and compliance with the medicine administration policies and procedures. At interview they demonstrated clear understanding of their roles and responsibilities related to each stage of medication management. The RN oversees the use of all pro re nata (PRN) medicines and documentation made regarding effectiveness on the electronic medication record and in the progress notes was sighted. Current medication competencies were evident in staff files. Education for residents regarding medications occurs on a one-to-one basis by the CSM or RN. Medication information for residents and whānau can be accessed online as needed. There were two residents self-administering medication on the day of the audit. Safe storage and documentation of medications taken complied with UCG policy. However, initial assessment, approval and ongoing competency assessment requires improvement. Standing orders were in place, all were documented and signed by

		the GP. 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 prescribed by, a medical practitioner. Interview with the GP confirmed that they would discuss the use of over-the-counter medications and traditional Māori medications with residents and their whanau when required. The UCG medication policy and Māori health plan outlines the requirements for support, advice, and treatments options for Māori residents.
Subsection 3.5: Nutrition to support wellbeing The people: Service providers meet my nutritional needs and consider my food preferences. Te Tiriti: Menu development respects and supports cultural beliefs, values, and protocols around food and access to traditional foods. As service providers: We ensure people's nutrition and hydration needs are met to promote and maintain their health and wellbeing.	PA Low	A nutritional assessment is undertaken by the RN for each resident on admission to identify the residents' dietary requirements and preferences. The nutritional profiles are communicated to the kitchen staff and updated when a resident's dietary needs change. Diets are modified as needed and the cook at interview confirmed awareness of the dietary needs, likes and dislikes of residents. These are accommodated in daily meal planning. For residents identifying as Māori information is gathered regarding nutritional needs and preferences during the initial assessment and during the development of their individual Māori care plan. Residents can participate in food preparation as part of the activity programme and can be involved with the dining experience by assisting staff prepare the dining rooms prior to mealtimes. All meals are prepared on site and served in one of the three dining rooms or in the residents' rooms if requested. The temperature of food served is taken and recorded. Residents were observed to be given sufficient time to eat their meal and assistance was provided when necessary. Residents and families interviewed stated that they were satisfied with the meals provided. The food service is provided in line with recognised nutritional guidelines for older people. The seasonal menu has been reviewed by a dietitian, with the winter menu implemented at the time of audit. The food control plan expiry date is July 2023. The kitchen staff have relevant infection control training. However,

		training for all kitchen staff in food safety and handling is not current. 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 comply with current legislation and guidelines. The cook is responsible for purchasing the food to meet the requirements of the menu plans. Food is stored appropriately in fridges and freezers. Temperatures of fridges and the freezer are monitored and recorded daily. Dry food supplies are stored in the pantry and rotation of stock occurs. All dry stock containers are labelled and dated. Discussion and feedback on the menu and food provided is sought at the monthly food forum and in the annual residents' survey.
Subsection 3.6: Transition, transfer, and discharge The people: I work together with my service provider so they know what matters to me, and we can decide what best supports my wellbeing when I leave the service. Te Tiriti: Service providers advocate for Māori to ensure they and whānau receive the necessary support during their transition, transfer, and discharge. As service providers: We ensure the people using our service experience consistency and continuity when leaving our services. We work alongside each person and whānau to provide and coordinate a supported transition of care or support.	FA	There is an UCG resident transfer/discharge policy. Transition, exit, discharge, or transfer is managed in a planned and coordinated manner and includes ongoing consultation with residents and family/whānau. The service facilitates access to other medical and non-medical services. Residents/whānau are advised of options to access other health and disability services and social support or Kaupapa Māori agencies if indicated or requested. Where needed, referrals are sent to ensure other health services, including specialist care is provided for the resident. Referral forms and documentation are maintained on resident files. Referrals are regularly followed up. Communication records reviewed in the residents' files, confirmed family/whānau are kept informed of the referral process. Interviews with the CSM and RN and review of residents' files confirmed there is open communication between services, the resident, and the family/whānau. Relevant information is documented and communicated to health providers. A transfer form accompanies residents when a patient is moved to another service or facility.

		Follow-up occurs to check that the resident is settled.
Subsection 4.1: The facility The people: I feel the environment is designed in a way that is safe and is sensitive to my needs. I am able to enter, exit, and move around the environment freely and safely. Te Tiriti: The environment and setting are designed to be Māori-centred and culturally safe for Māori and whānau. As service providers: Our physical environment is safe, well maintained, tidy, and comfortable and accessible, and the people we deliver services to can move independently and freely throughout. The physical environment optimises people's sense of belonging, independence, interaction, and function.	PA Moderate	A current building warrant of fitness is displayed in the entrance to the facility. Buildings, plant, and equipment comply with relevant legislation. A preventative and reactive maintenance schedule is implemented. This includes monthly maintenance checks of all areas and specified equipment such as hoists. Staff identify maintenance issues on an electronic system. This information is reviewed by the maintenance person and attended to as required. Interviews confirmed staff awareness of the processes for maintenance requests and that repairs were conducted in a timely manner. Interviews with staff and visual inspection confirmed there is adequate equipment available to support care. The facility has an up-to-date annual test and tag programme. Evidence of checking and calibration of biomedical equipment, such as hoists was sighted. There is a system to ensure that the facility van that is used for residents' outings is routinely maintained. Inspection confirmed that the van has a current registration, warrant of fitness, first aid kit, fire extinguisher and functioning hoist. Staff interviews and documentation evidenced that those staff who drive the van have a current driver's licence and first aid certificate. Hot water temperatures are assayed monthly. A review of recorded hot water temperature assays and interview with the maintenance person confirmed that hot water temperatures have been maintained at the recommended safe temperature. All resident areas can be accessed with mobility aides. There are accessible external courtyards and gardens. All external areas have outdoor seating and shade and can be accessed freely by residents and their visitors. There are adequate numbers of accessible showers, hand basins and toilets throughout the facility, with a combination of ensuites,

		communal toilet/bathing facilities and visitors' toilets. Communal toilets have a system to indicate vacancy and have disability access. Visitors' toilets and residents' toilets are located close to communal areas. All shower and toilet facilities have call bells; sufficient room; approved handrails; and other equipment to facilitate ease of mobility and to promote independence. 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 assistance. Observation and interviews with residents confirmed that there was enough space to accommodate: personal items; furniture; equipment and staff as required. There are designated areas within the facility to store equipment such as wheelchairs, walking frames, commodes and hoists, tidily. There are dining rooms and lounges and a central kitchen. There are a number of small nooks with seating. All internal communal areas have seating and external views. Areas can be easily accessed by residents, family/whānau, and staff. There are areas that are available for residents to access with their visitors for privacy, if they wish. Observation and interviews with residents and family/whānau confirmed that residents can move freely around the facility and that the accommodation meets residents' needs. There are areas for storing activities equipment and resources. There are areas in each wing, including lounge areas, that are used for activities. Most residents were observed to have their meals with other residents in the communal dining rooms but can have their meal in their own room if they wish. All residents' rooms and communal areas accessed by residents have safe ventilation and at least one external window providing natural light. Resident areas in the facility are heated in the winter. The

		environment in resident areas was noted to be maintained at a satisfactory temperature. This was confirmed in interviews with staff and residents. The facility has a one designated external smoking area for residents.
Subsection 4.2: Security of people and workforce The people: I trust that if there is an emergency, my service provider will ensure I am safe. Te Tiriti: Service providers provide quality information on emergency and security arrangements to Māori and whānau. As service providers: We deliver care and support in a planned and safe way, including during an emergency or unexpected event.	PA Low	Staff files and training records demonstrated that orientation and mandatory training includes emergency and disaster procedures and fire safety. An approved fire evacuation plan was sighted. Interviews with staff and review of documentation confirmed that fire drills are conducted at least six-monthly. There is a sprinkler system installed throughout the facility and exit signage displayed. Staff interviews, and training records confirm that fire wardens received warden training and staff have undertaken fire training. The staff competency register evidenced that there is a system to ensure staff maintain first aid currency, however this had not been completed. The facility has sufficient supplies to sustain staff and residents in an emergency situation. Alternative energy and utility sources are available in the event of the main supplies failing. These include: a generator (from the local fire department), barbeque and gas for cooking; emergency lighting; and enough food, water, dressings and continence supplies. The service's emergency plan includes considerations of all levels of resident need. All hand basins used for hand washing, including those in residents' rooms, have access to flowing soap and paper towels. These were observed to be used correctly by staff and visitors. Call bells are available to summon assistance in all resident rooms and bathrooms. Call bells are checked monthly by the maintenance person. Observation and resident interviews confirmed that call bells are answered promptly. Security systems are in place to ensure the protection and safety of residents, visitors, and staff. These include visitors signing in and out

		of the building and the facility being locked in the evenings with restricted entry after hours. Family/whānau are aware of the security measures and fire systems with notices placed in all wings.
Subsection 5.1: Governance The people: I trust the service provider shows competent leadership to manage my risk of infection and use antimicrobials appropriately. Te Tiriti: Monitoring of equity for Māori is an important component of IP and AMS programme governance. As service providers: Our governance is accountable for ensuring the IP and AMS needs of our service are being met, and we participate in national and regional IP and AMS programmes and respond to relevant issues of national and regional concern.	FA	Infection prevention (IP) 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 control programme. UCG have, as part of their senior management team, personnel with expertise in IP and AMS. These positions are the head of resident risk, the head of resident care, and the nursing coach. Expertise can also be accessed from “Bug Control” who supply the UCG with infection control resources. There is a documented pathway for reporting IP and AMS issues to the UCG Board. The clinical team report to the UCG general manager (GM) who reports to the board. The UCG reflection report ensures that reporting occurs from governance back to site level. There are policies and procedures in place to manage significant IP events. Any significant events are managed using a collaborative approach and involve the infection control nurse (ICN), the UCG national clinical team, the GP, and the public health team. External resources and support are available through external specialists, microbiologist, GP, wound nurse and the DHB when required. Overall effectiveness of the programme is monitored by the facility management team. The CSM has recently been appointed to the ICN role. They have not yet had training for the role, however training is scheduled. A documented and signed role description for the ICN is in place. The ICN reports to the FM. There are adequate resources to implement the infection control programme at UC Ranburn.

		Infection control reports are discussed at the facility's meetings. The ICN has access to all relevant resident data to undertake surveillance, internal audits, and investigations. Staff interviewed demonstrated an understanding of the infection prevention and control programme.
Subsection 5.2: The infection prevention programme and implementation The people: I trust my provider is committed to implementing policies, systems, and processes to manage my risk of infection. Te Tiriti: The infection prevention programme is culturally safe. Communication about the programme is easy to access and navigate and messages are clear and relevant. As service providers: We develop and implement an infection prevention programme that is appropriate to the needs, size, and scope of our services.	FA	The infection prevention and control programme is appropriate for the size and complexity of the service. The infection prevention and control programme is reviewed annually and is linked to the quality and business plan. There are documented policies and procedures in place that reflect current best practice relating to infection prevention and control and include policies for hand hygiene, aseptic technique, transmission-based precautions, prevention of sharps injuries, prevention and management of communicable infectious diseases, management of current and emerging multidrug-resistant organisms (MDRO), outbreak management, single use items, healthcare acquired infection (HAI) and the built environment. Infection prevention and control resources including personal protective equipment (PPE) were available should a resident infection or outbreak occur. Staff were observed to be complying with the infection control policies and procedures. Staff demonstrated knowledge on the requirements of standard precautions and were able to locate policies and procedures. Ultimate Care Group have a pandemic response plan in place which is reviewed and tested at regular intervals. The UCG clinical operations group (COGS) involve staff at site level in the review of policies and procedures, the ICN has input when IP policies and procedures are reviewed. The ICN is responsible for coordinating/providing education and training to staff. The orientation package includes specific training around hand hygiene and standard precautions. Annual infection control training is included in the mandatory in-services that are held for all staff. Staff have completed infection control education in the last 12 months. The ICN has access to an online training system with

		resources, guidelines, and best practice. Infection control audits have been completed. At site level the ICN has responsibility for purchasing thermometers, face masks and face shields. All other equipment/resources are purchased at national level. Infection prevention input into new buildings or significant changes occurs at national level and involves the head of resident risk and the regional managers. There is a policy in place for decontamination of reusable medical devices and this is followed. Single use medical devices are not reused. Educational resources in te reo Māori can be accessed online if needed. All residents are included and participate in IP. Staff are trained in cultural safety. There have been two outbreaks at the facility since the last audit. Both were reported to Public Health and managed appropriately and effectively.
Subsection 5.3: Antimicrobial stewardship (AMS) programme and implementation The people: I trust that my service provider is committed to responsible antimicrobial use. Te Tiriti: The antimicrobial stewardship programme is culturally safe and easy to access, and messages are clear and relevant. As service providers: We promote responsible antimicrobials prescribing and implement an AMS programme that is appropriate to the needs, size, and scope of our services.	FA	There are approved policies and guidelines for antimicrobial prescribing. Prescribing of antimicrobial use is monitored, recorded, and analysed at site level. Further discussion takes place at senior management level and is reported to the board. Trends are identified both at site level and national level. Feedback occurs in the UCG reflection report.
Subsection 5.4: Surveillance of health care-associated infection	FA	Surveillance is an integral part of the infection control programme. The purpose and methodology are described in the UCG surveillance

(HAI) The people: My health and progress are monitored as part of the surveillance programme. Te Tiriti: Surveillance is culturally safe and monitored by ethnicity. As service providers: We carry out surveillance of HAIs and multi-drug-resistant organisms in accordance with national and regional surveillance programmes, agreed objectives, priorities, and methods specified in the infection prevention programme, and with an equity focus.		policy in use at the facility. The ICN uses the information obtained through surveillance to determine infection control activities, resources and education needs within the service. Monthly infection data is collected for all infections based on standard definitions. Infection control data is monitored and evaluated monthly and annually. Trends are identified and analysed, and corrective actions are established where trends are identified. These, along with outcomes and actions are discussed at the RN, quality, and staff meetings. Meeting minutes are available to staff. Staff are made aware of new infections at handovers on each shift, progress notes and clinical records. Short term care plans are developed to guide care for all residents with an infection. There are processes in place to isolate infectious residents when required. Education for residents regarding infections occurs on a one-to-one basis and includes advice and education about hand hygiene, medications prescribed and requirements if appropriate for isolation. Hand sanitisers and gels are available for staff, residents, and visitors to the facility. Ministry of Health information and Covid-19 information is available to all visitors to the facility.
Subsection 5.5: Environment The people: I trust health care and support workers to maintain a hygienic environment. My feedback is sought on cleanliness within the environment. Te Tiriti: Māori are assured that culturally safe and appropriate decisions are made in relation to infection prevention and environment. Communication about the environment is culturally safe and easily accessible. As service providers: We deliver services in a clean, hygienic environment that facilitates the prevention of infection and	FA	The facility implements UCG waste and hazardous management policies that conform to 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; and disposal of general, infectious, and hazardous waste. Current material safety data information sheets are available and accessible to staff in relevant places in the facility, such as the sluice room. Staff complete a chemical safety training module on orientation. Staff receive training and education in waste management and infection control as a component of the mandatory training. Interviews and observations confirmed that there is enough PPE and

transmission of antimicrobialresistant organisms.		equipment provided, such as aprons, gloves, and masks. Interviews confirmed that the use of PPE is appropriate to the recognised risks. Observation confirmed that PPE was used in high-risk areas. Laundry and cleaning services are provided seven days a week. Sampled rosters confirmed that cleaning and laundry duties are rostered part time each day, with caregivers on afternoon and night shifts completing the work. Visual inspection, of the on-site laundry demonstrated the implementation of a clean/dirty process for the hygienic washing, drying, and handling of personal clothes and facility linen. The safe and hygienic collection and transport of laundry items into relevant colour containers was witnessed. Household and laundry personnel interviewed demonstrated knowledge of the process to handle and wash infectious items when required. Residents' clothing is labelled and personally delivered from the laundry, as observed. Residents and families confirmed satisfaction with laundry services in interviews and in satisfaction surveys. Cleaning duties and procedures are documented to ensure correct cleaning processes occur. Cleaning products are dispensed from an in-line system according to the cleaning procedure. There are designated locked cupboards for the safe and hygienic storage of cleaning equipment and chemicals. Household personnel interviewed are aware of the requirement to keep their cleaning trolleys in sight. Chemical bottles/cans in storage and in use were noted to be appropriately labelled. 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 control team. There were no construction, installation, or maintenance in progress at the time of the audit.
Subsection 6.1: A process of restraint	FA	The restraint approval process is described in the restraint minimisation policy. Policies and procedures meet the requirements of

The people: I trust the service provider is committed to improving policies, systems, and processes to ensure I am free from restrictions. Te Tiriti: Service providers work in partnership with Māori to ensure services are mana enhancing and use least restrictive practices. As service providers: We demonstrate the rationale for the use of restraint in the context of aiming for elimination.		the restraint minimisation and safe practice standards and provide guidance on the safe use of restraints. The restraint coordinator is the FM and provides support and oversight for restraint management in the facility. The restraint coordinator is conversant with restraint policies and procedures. An interview the UCG national restraint co-ordinator described the organisation's commitment to restraint minimisation and implementation. The reporting process to the governance body includes data gathered and analysed monthly that supports the ongoing safety of residents and staff. Family/whānau approval would be gained should any resident be unable to consent and any impact on family/whānau is also considered. Regular training occurs at orientation and annually. Review of restraint use is completed and discussed at all staff meetings.
Subsection 6.2: Safe restraint The people: I have options that enable my freedom and ensure my care and support adapts when my needs change, and I trust that the least restrictive options are used first. Te Tiriti: Service providers work in partnership with Māori to ensure that any form of restraint is always the last resort. As service providers: We consider least restrictive practices, implement de-escalation techniques and alternative interventions, and only use approved restraint as the last resort.	PA Low	The restraint policy details the process for assessment. Assessment covers the need, alternatives attempted, risk, cultural needs, impact on the family/whānau, any relevant life events, any advance directives, expected outcomes and when the restraint will end. The restraint coordinator discusses alternatives with the resident, family/whānau, GP, and staff taking into consideration wairuatanga. Alternatives to restraint include low beds, perimeter mattresses, and sensor mats. If restraint is used, documentation should include the method approved, when it should be applied, frequency of monitoring and when it should end. It also details the date, time of application and removal, risk/safety checks, food/fluid intake, pressure area care, toileting, and social interaction during the process. Interviews with staff confirmed that they were aware of restraint monitoring requirements and restraint is used as a last resort when all

		alternatives have been explored. No approved restraints are being used. However, an area for improvement was identified. On the day of audit, it was noted that some residents who had been deemed at risk of getting out of bed unaided had a mattress on the floor beside their beds to restrict movement. A restraint register is maintained and reviewed by the restraint coordinator who shares the information with staff at the quality, staff, and clinical meetings. Evaluation includes a review of the process and documentation, including the resident's care plan and risk assessments, future options to eliminate use and the impact and outcomes achieved. Evaluations are discussed at the staff meetings and at the UCG national restraint committee meetings.
Subsection 6.3: Quality review of restraint The people: I feel safe to share my experiences of restraint so I can influence least restrictive practice. Te Tiriti: Monitoring and quality review focus on a commitment to reducing inequities in the rate of restrictive practices experienced by Māori and implementing solutions. As service providers: We maintain or are working towards a restraint-free environment by collecting, monitoring, and reviewing data and implementing improvement activities.	FA	A review of documentation and interview with the UCG national restraint co-ordinator demonstrated that there was monitoring and quality review of the use of restraints. The internal audit schedule was reviewed, and it included review of restraint minimisation. The content of the internal audits included the effectiveness of restraints, staff compliance, safety, and cultural considerations. Staff monitor restraint related adverse events if restraint is in use. Any changes to policies, guidelines or education are implemented if indicated. Data reviewed, minutes and interviews with staff including RNs and caregivers confirmed that the use of restraint is only used as a last resort.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 2.2.3 Service providers shall evaluate progress against quality outcomes.	PA Low	Quality, health and safety, staff meetings are held monthly, and minutes are taken and available for staff to read, however improvement is required to ensure staff are fully informed regarding the evaluation and outcomes of corrective action plans.	Quality, health and safety, staff meetings do not fully inform staff of corrective action plans evaluations and outcomes.	Quality, health and safety, staff meetings should clearly outline corrective actions and improvements. 90 days
Criterion 2.3.1 Service providers shall ensure there are sufficient health care and support workers on duty at all times to provide culturally and clinically safe services.	PA Low	There is not consistently 24/7 RN cover for the facility as required under the DHB ARRC agreement. Mitigation of this risk has been put into place with monitoring by the DHB. Whenever a RN is not available, a level four NZQA qualified senior caregiver who has a current first aid certificate and medication competencies, covers the shift.	Facility does not have 24/7 RN cover as required under the ARRC agreement.	Ensure there is 24/7 RN cover. 90 days

Criterion 2.3.2 Service providers shall ensure their health care and support workers have the skills, attitudes, qualifications, experience, and attributes for the services being delivered.	PA Moderate	There are currently only two staff members who work within the secure dementia wing that have achieved NZQA standards 23290, 23921, 23922 and 23923 as required under the DHB ARRC agreement. There has been only one enrolment for other staff members to achieve this requirement.	Staff who have been employed for more than 18 months and new staff working in the unit have not been enrolled in NZQA dementia training.	The provider is to ensure that all staff working in the secure dementia wing have the required NZQA qualifications or are enrolled in a course. 30 days
Criterion 2.4.5 Health care and support workers shall have the opportunity to discuss and review performance at defined intervals.	PA Low	Annual appraisals have not been carried out as per policy for the last twelve months, however the facility now has a corrective action plan in place to address this oversight.	Annual appraisals have not been carried out for staff employed for 12 months or more.	Ensure all staff have annual appraisals carried out. 90 days
Criterion 3.2.1 Service providers shall engage with people receiving services to assess and develop their individual care or support plan in a timely manner. Whānau shall be involved when the person receiving services requests this.	PA Moderate	All residents' files reviewed evidenced that assessment, care planning and evaluation occurred within the required timeframes, however, there was no evidence in eight out of eight files reviewed that family/whānau had any input into the assessment, care planning or evaluation process. This area for improvement had been identified by the regional clinical manager and a corrective action plan has been developed but not yet implemented. All residents had a long-term care plan in place. However, interventions in the long-term care plans were not consistently documented in sufficient detail to address their assessed needs. In the long-term care plans for the four residents with pressure injuries interventions were not described in sufficient detail to guide staff to meet the residents assessed pressure injury risk and	i) There is no evidence that family/whānau have input into the assessment, care planning and evaluation processes. ii) Long-term care plans did not describe sufficient detail to guide staff to meet the residents assessed pressure injury risk and care needs.	i) Ensure that family/whānau are given the opportunity to participate in the assessment, care planning and evaluation processes when the person receiving care requests this. ii) Ensure pressure injury prevention supports and interventions are included in care plans for residents identified at risk of developing pressure injuries. 60 days

		care needs.		
Criterion 3.3.1 Meaningful activities shall be planned and facilitated to develop and enhance people's strengths, skills, resources, and interests, and shall be responsive to their identity.	PA Low	All residents living in the dementia wing had assessments on admission relating to their previous life experiences, interests, and pastoral care needs. However, the care plans do not describe activities in sufficient detail to meet the residents' assessed needs over the 24-hour period.	The activities documented in the care plans of the residents living in the secure dementia wing are not described in sufficient detail to meet their assessed needs over 24 hours.	Ensure that activities for residents living in the secure dementia wing are documented in sufficient detail to meet their assessed needs over 24 hours. 90 days
Criterion 3.4.3 Service providers ensure competent health care and support workers manage medication including: receiving, storage, administration, monitoring, safe disposal, or returning to pharmacy.	PA Moderate	Secure storage of medication is maintained in the two medication rooms. However, the temperature of one of the medication rooms is not monitored and the rest home refrigerator temperature had been above the required level eight times in the past month and no corrective action has been taken.	Temperature monitoring of the medication refrigerators and medication rooms is not carried out in accordance with UCG policy and best practice.	Ensure that temperature monitoring of the medication refrigerators and medication rooms is carried out in accordance with UCG policy and best practice. 30 days
Criterion 3.4.6 Service providers shall facilitate safe self-administration of medication where appropriate.	PA Moderate	Safe storage is provided for residents who are self-administering medications. However, the approval, assessment and competency checks for residents self-administering medications is not carried out in accordance with UCG policy. There were two residents self-administering medications, the initial assessments for competence had been only partially completed and ongoing competency checks had not occurred.	Self-administering medication procedures are not maintained in accordance with UCG policy and best practice.	Ensure that self-administering medication procedures are maintained as per UCG policy. 30 days

Criterion 3.5.5 An approved food control plan shall be available as required.	PA Low	The food control plan is current, it expires in July 2023. However, the food safety and handling qualifications for staff working in the kitchen, including the chef, are not current.	The chef and kitchen staff do not have current food safety qualifications.	Ensure that staff working in food preparation have current safe food handling qualifications. 90 days
Criterion 4.1.2 The physical environment, internal and external, shall be safe and accessible, minimise risk of harm, and promote safe mobility and independence.	PA Moderate	There is an open resident/whanau kitchen with a hot water unit for tea/coffee making, available at all times. This unit provides water above 45 degrees Celsius and is readily accessible to residents.	There is no safety guard on the hot water dispensing unit to prevent scalding of residents or visitors.	Ensure that the resident/whānau hot water unit has a safety guard installed. 30 days
Criterion 4.2.4 Service providers shall ensure health care and support workers are able to provide a level of first aid and emergency treatment appropriate for the degree of risk associated with the provision of the service.	PA Low	The facility has a staff member on duty on the morning shifts who is trained in first aid on duty. However, the requirement to have a first aid competent healthcare worker on duty is not met in the afternoon and night shifts.	A first aid competent healthcare worker is not on duty on afternoon and night shifts	The provider is to ensure that a healthcare or support worker/s who is trained in first aid is on duty on each shift. 60 days
Criterion 6.2.4 Each episode of restraint shall be documented on a restraint register and in people's records in sufficient detail to provide an accurate rationale for use, intervention, duration, and outcome of the restraint, and shall include: (a) The type of restraint used; (b) Details of the reasons for initiating the restraint;	PA Low	Restraint minimisation policies and procedures are in place. However, it was observed that mattresses were being used on the floor next to the beds of residents who had been deemed at risk of getting out of bed unaided. The mattresses restricted the residents ability to mobilise once out of their bed. Using a mattress on the floor by a resident's bed is not a UCG approved restraint. Interview with the UCG national restraint co-ordinator confirmed this. Seven mattresses were being used with the intent	A non-approved method of restraint is being used which is not in accordance with UCG policy or best practice.	Ensure that only UCG approved restraint is used. 30 days

(c) The decision-making process, including details of de-escalation techniques and alternative interventions that were attempted or considered prior to the use of restraint; (d) If required, details of any advocacy and support offered, provided, or facilitated; NOTE – An advocate may be: whānau, friend, Māori services, Pacific services, interpreter, personal or family advisor, or independent advocate. (e) The outcome of the restraint; (f) Any impact, injury, and trauma on the person as a result of the use of restraint; (g) Observations and monitoring of the person during the restraint; (h) Comments resulting from the evaluation of the restraint; (i) If relevant to the service: a record of the person-centred debrief, including a debrief by someone with lived experience (if appropriate and agreed to by the person). This shall document any support offered after the restraint, particularly where trauma has occurred (for example, psychological or cultural trauma).		of restricting resident movement. No documentation was in place to support the use of the mattresses. Following discussion with the UCG national restraint co-ordinator action to discontinue the use of the mattresses was to be implemented as soon as possible.		

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.