

# The Ultimate Care Group Limited - Ultimate Care Bishop Selwyn

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## 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:

<b>Legal entity:</b>	The Ultimate Care Group Limited	
<b>Premises audited:</b>	Ultimate Care Bishop Selwyn	
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)	
<b>Dates of audit:</b>	Start date: 5 September 2023	End date: 6 September 2023
<b>Proposed changes to current services (if any):</b>	None	
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	59	

# Executive summary of the audit

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## 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 haumarū | person-centred and safe environment
- te kaupare pokenga me te kaitiakitanga patu huakita | infection prevention and antimicrobial stewardship
- here taratahi | restraint and seclusion.

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

### Key to the indicators

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

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

## General overview of the audit

Ultimate Care Bishop Selwyn is part of the Ultimate Care Group Limited. It is certified to provide services for up to 78 residents requiring rest home, or hospital level care. Since the previous audit a new facility manager had been appointed.

This certification audit was conducted against the Ngā Paerewa Health and disability services standard NZS 8134:2021 and the service contracts with Te Whatu Ora Waitaha Canterbury. The audit process included review of policies and procedures, review of resident and staff files, observations and interviews with staff, residents, whānau a general practitioner and the national programmes manager for Ultimate Care.

Areas identified as requiring improvement relate to partnerships with Māori and Pacific communities, complaint management and surveillance reporting.

## Ō tatou motika | Our rights

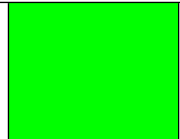
Includes 10 subsections that support an outcome where people receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of people's rights, facilitates informed choice, minimises harm, and upholds cultural and individual values and beliefs.		Some subsections applicable to this service partially attained and of low risk.
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The service complies with Health and Disability Commission Code of Health and Disability Consumer's Rights (the Code). Residents receive services in a manner that considers their dignity, privacy, independence and facilitates their informed choice and consent. Care plans accommodate the choices of residents and/or their whānau.

Staff 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 considers values, beliefs, culture, religion, and relationship status.

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

## 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.		Subsections applicable to this service fully attained.
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Ultimate Care Group is the governing body responsible for the services provided. The organisation's mission statement and vision were documented and displayed. The facility has a current business plan and a quality risk management plan.

An experienced and suitably qualified facility manager ensures the management of the facility with the support of a clinical services manager. A regional manager (acting) supports the facility manager.

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

There were human resource policies and procedures that guide practice in relation to recruitment, orientation, and management of staff. A systematic approach to identify and deliver ongoing training supports safe service delivery.

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

## Ngā huarahi ki te oranga | Pathways to wellbeing

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

Subsections applicable to this service fully attained.

Information is provided in accessible formats to residents and their whānau on entry to the service. Registered nurses assess residents on admission with input from the resident and/or whānau. The initial care plan guides care and service provision during the first three weeks after the resident's admission.

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

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

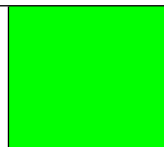
The activity programme is managed by a diversional therapist. The programme provides residents with a variety of individual and group activities and maintains their links with the community.

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

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

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

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



Subsections applicable to this service fully attained.

The building warrant of fitness is current until July 2024. A reactive and preventative maintenance programme is implemented. External areas are safe and provide seating and shade.

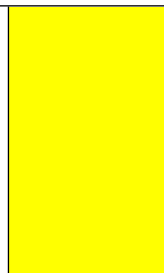
Residents' rooms are of an appropriate size for the safe use of and manoeuvring of mobility aids and provision of care. Lounges and dining areas provide spaces for residents and their visitors. Communal and individual spaces are maintained at a comfortable temperature.

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

Emergency and security arrangements are outlined to all people using the services and/or entering the facility.

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

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




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

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

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

There are organisational COVID-19 prevention strategies in place including a pandemic plan. There has been one COVID-19 outbreak since the last audit which was managed according to internal policy, contract, and reporting requirements. Notifications and debriefing activities were completed as required.

## Here taratahi | Restraint and seclusion

Includes 4 subsections that support outcomes where Services shall aim for a restraint and seclusion free environment, in which people's dignity and mana are maintained.		Subsections applicable to this service fully attained.
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Restraint minimisation and safe practice policies and procedures are in place. Restraint minimisation is overseen by the restraint coordinator. On the day of the on-site audit, there were no residents using a restraint. Restraint is only used as a last resort when all other options have been explored.

There have been no recorded incidents of restraint since the last audit. Staff have completed restraint elimination and safe practice training. Information related to restraint is available at governance level and to facility staff. Quality meetings include restraint practice.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Subsection	0	23	0	4	0	0	0
Criteria	0	163	0	5	0	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

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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
<p>Subsection 1.1: Pae ora healthy futures</p> <p>Te Tiriti: Māori flourish and thrive in an environment that enables good health and wellbeing.</p> <p>As service providers: We work collaboratively to embrace, support, and encourage a Māori worldview of health and provide high-quality, equitable, and effective services for Māori framed by Te Tiriti o Waitangi.</p>	<p>PA Low</p>	<p>Staff receive training in cultural safety at orientation. The organisation has developed a cultural safety module that is provided as part of the mandatory annual education programme. It defines and explains cultural safety and its importance including Te Tiriti o Waitangi and tikanga best practice. Current staff had completed the training except staff who were still completing orientation.</p> <p>The organisation has a Māori health action plan that recognises the principles of Te Tiriti o Waitangi. and describes how the Ultimate Care Group (UCG) responds to Māori cultural needs in relation to health and illness.</p> <p>The health plan outlines that the recruitment of Māori staff will be encouraged, and the facility manager (FM) outlined examples of how this is implemented. The plan describes the aims of UCG to ensure outcomes for Māori are positive and equitable. Strategies include but are not limited to, identifying priority areas for leadership to focus on, and increasing the knowledge base across the organisation underpinned by Mātauranga Māori. The document outlines the importance of ensuring</p>

		<p>any resident who identified as Māori would have the opportunity to have whānau involved in their care. Documents are provided in te reo Māori.</p> <p>The facility is yet to formalise links or create formal partnerships with local Māori. At time of audit there were residents who identified as Māori.</p>
<p>Subsection 1.2: Ola manuia of Pacific peoples in Aotearoa</p> <p>The people: Pacific peoples in Aotearoa are entitled to live and enjoy good health and wellbeing.</p> <p>Te Tiriti: Pacific peoples acknowledge the mana whenua of Aotearoa as tuakana and commit to supporting them to achieve tino rangatiratanga.</p> <p>As service providers: We provide comprehensive and equitable health and disability services underpinned by Pacific worldviews and developed in collaboration with Pacific peoples for improved health outcomes.</p>	PA Low	<p>The Pacific plan outlines the organisations commitment to providing culturally safe care and defines the cultural and spiritual beliefs of Pacific peoples. The policy is underpinned by Pacific models of care with UCG senior staff accessing information to support the plan from Pacific communities. The FM outlined that a community connection is yet to be developed with the local Pacific community.</p> <p>Information gathered during the admission process includes identifying a resident’s specific cultural needs, spiritual values, and beliefs.</p> <p>The organisation has developed a strategy that ensures that a Pacific health and wellbeing workforce is recruited, retained, and trained across the organisation. The FM outlined how this is implemented.</p> <p>There were no Pacific peoples residing in the facility at time of audit.</p>
<p>Subsection 1.3: My rights during service delivery</p> <p>The People: My rights have meaningful effect through the actions and behaviours of others.</p> <p>Te Tiriti: Service providers recognise Māori mana motuhake (self-determination).</p> <p>As service providers: We provide services and support to people in a way that upholds their rights and complies with legal requirements.</p>	FA	<p>The Code of Health and Disability Services Consumers’ Rights (the Code) was on display in each wing of the facility, written in English and te reo Māori.</p> <p>Education records confirmed that staff had completed training that covered the Code. Staff discussed the Code, and provided examples of how they met the Code when providing day to day care. Observation during the audit confirmed that the provision of care was provided in accordance with the Code. Residents and whānau were provided written information about the Code on admission and stated they were provided with opportunities to discuss their rights. Residents and whanau advised they had been consulted about the care plan and were involved in decisions pertaining to their care. Māori residents confirmed that they made independent decisions and were able to include whānau as desired.</p>

		<p>Staff outlined they were aware of the advocacy service and how to support residents to make contact with the national advocacy service.</p> <p>Policy and practice include ensuring that all residents including any Māori residents right to self-determination is upheld and they can practise their own personal beliefs and values. The Māori health action plan identifies how UCG responds to Māori cultural needs in relation to health and illness.</p>
<p>Subsection 1.4: I am treated with respect</p> <p>The People: I can be who I am when I am treated with dignity and respect.</p> <p>Te Tiriti: Service providers commit to Māori mana motuhake. As service providers: We provide services and support to people in a way that is inclusive and respects their identity and their experiences.</p>	FA	<p>The provider ensures that residents and whānau are involved in planning and care, which is inclusive of discussions and choices regarding maintaining independence. Resident, whānau, and staff interviews, plus observation confirmed that individual religions, social preferences, values, and beliefs are identified and upheld. These were also documented in resident files.</p> <p>The facility has policies and procedures that are aligned to the requirements of the Privacy Act and Health Information Privacy Code to ensure that resident's right to privacy and dignity are upheld. Residents, whānau, and staff interviewed confirmed that staff knock on doors before entering, ensure doors are closed when personal cares and being provided, and confidentiality is maintained when staff are holding conversations that are personal in nature.</p> <p>Staff receive training in tikanga best practice and have additional resources available to provide ongoing guidance. The FM outlined that staff are encouraged to use basic greetings in te reo Māori with a focus maintained in ensuring the correct pronunciation.</p> <p>The organisation supports tāngata whaikaha to do well with documentation outlining how staff will support with goal setting and achievement with all aspects of service delivery.</p>
<p>Subsection 1.5: I am protected from abuse</p> <p>The People: I feel safe and protected from abuse.</p> <p>Te Tiriti: Service providers provide culturally and clinically safe services for Māori, so they feel safe and are protected from</p>	FA	<p>There is policy that includes definitions, guidelines, and responsibilities for staff to report alleged or suspected abuse. Staff receive orientation and mandatory training in abuse and neglect. Interviews confirmed staff awareness of their obligations to report any incidences of suspected</p>

<p>abuse. As service providers: We ensure the people using our services are safe and protected from abuse.</p>		<p>abuse. Staff and whānau interviews confirmed there was no evidence of abuse or neglect.</p> <p>The admission agreement signed prior to occupation provides clear expectations regarding management responsibilities of personal property and finances. Residents and/or their whānau provide consent for the administrator to manage the residents comfort funds. Discussion with the administrator and review of documentation evidenced that appropriate systems are in place that ensures the safe management of residents' comfort funds. Residents and/or their whānau provided further confirmation that resident property is respected.</p> <p>There are policies and procedures to ensure that the environment is free from discrimination, racism, coercion, harassment, and financial exploitation. They provide guidance to staff on how this is prevented, and where suspected, the reporting process.</p> <p>Staff are required to sign and abide by the UCG code of conduct and professional boundaries agreement. All staff files sampled evidenced these were signed. Staff mandatory training includes maintaining professional boundaries. Discussion with staff confirmed their understanding of professional boundaries relevant to their respective roles. Residents and/or whānau confirmed that professional boundaries are maintained.</p> <p>Residents described how the provider demonstrates an environment in which they and/or their whānau feel safe and comfortable to raise any issues and discussions are free and open.</p> <p>A review of documentation and interviews with staff evidenced that the organisation has prioritised the introduction of the Māori model of care te whare tapa wha across service delivery.</p>
<p>Subsection 1.6: Effective communication occurs</p> <p>The people: I feel listened to and that what I say is valued, and I feel that all information exchanged contributes to enhancing my wellbeing.</p> <p>Te Tiriti: Services are easy to access and navigate and give clear and relevant health messages to Māori.</p>	<p>FA</p>	<p>There is policy to ensure that residents and their whānau have the right to comprehensive information supplied in a way that is appropriate and considers specific language requirements and disabilities. The FM confirmed that where required, interpreters are accessed from Te Whatu Ora Canterbury. At time of audit there were no residents that required an interpreter.</p>

<p>As service providers: We listen and respect the voices of the people who use our services and effectively communicate with them about their choices.</p>		<p>Resident files sampled evidenced that other healthcare agencies were involved in resident care providing additional assessments and treatment regimes as required.</p> <p>There is policy which requires whānau to be advised within 24 hours of an adverse event occurring. Review of incident and accident information confirmed that timeframes were met, and open disclosure had occurred where required following an event involving a resident.</p> <p>Two monthly resident/whānau meetings inform residents and their whānau of facility activities. Meetings are advertised in the activities planner with reminders of what is coming up placed on notice boards throughout the facility. Meetings follow a set agenda and are chaired by the FM. Meeting minutes plus staff and resident interviews demonstrate attendance by residents and their whānau. The meeting minutes capture issues raised, who is taking responsibility for follow up, the outcome of which is discussed, and the progress made. Resident meetings also offer an opportunity to provide feedback and make suggestions for improvement. Copies of the menu and activities plan are available to residents and their whānau.</p>
<p>Subsection 1.7: I am informed and able to make choices</p> <p>The people: I know I will be asked for my views. My choices will be respected when making decisions about my wellbeing. If my choices cannot be upheld, I will be provided with information that supports me to understand why.</p> <p>Te Tiriti: High-quality services are provided that are easy to access and navigate. Providers give clear and relevant messages so that individuals and whānau can effectively manage their own health, keep well, and live well.</p> <p>As service providers: We provide people using our services or their legal representatives with the information necessary to make informed decisions in accordance with their rights and their ability to exercise independence, choice, and control.</p>	<p>FA</p>	<p>There is an informed consent policy to ensure that a resident who has capacity/competence to consent to treatment or procedure has been given sufficient information to enable them to arrive at a reasoned and voluntary decision. Staff interview provided confirmation additional guidance is provided for staff in the event a resident is unable to provide consent. Competence to provide informed consent is determined by the General Practitioner (GP).</p> <p>Staff receive training on informed consent and informed choice during their orientation. All staff interviewed were cognisant of the procedures to uphold informed consent. The resident information pack includes information regarding consent. The clinical services manager (CSM) or admitting registered nurse explains and discusses informed consent to residents and/or their whānau during the admission process to ensure understanding. This includes consent for resuscitation and advanced directives. All resident records sampled had signatures for consent with enduring power of attorney (EPOA) signatures noted for those residents</p>

		<p>who were not competent. Additional consents signed for included student nurse participation in their care and resident photos.</p> <p>The informed consent policy acknowledges Te Tiriti o Waitangi and the impact of culture and identity of the determinants of the health and wellbeing of Māori. It requires health professionals to recognise these as relevant when issues of health care and Māori residents arises. Staff confirmed that additional support for Māori could be accessed via Te Whatu Ora Waitaha Canterbury should they require specific guidance in relation to tikanga and consent.</p>
<p>Subsection 1.8: I have the right to complain</p> <p>The people: I feel it is easy to make a complaint. When I complain I am taken seriously and receive a timely response. Te Tiriti: Māori and whānau are at the centre of the health and disability system, as active partners in improving the system and their care and support.</p> <p>As service providers: We have a fair, transparent, and equitable system in place to easily receive and resolve or escalate complaints in a manner that leads to quality improvement.</p>	<p>PA Low</p>	<p>The organisation has a complaints policy that is in line with Right 10 of the Code. The complaint process is made available in the admission agreement and explained by the admitting nurse. Complaint forms are easily accessed within the facility and the UCG website enables complaints to be lodged online.</p> <p>The FM is responsible for managing complaints. There had been nine complaints over the 2021-2023 period thus far. A complaints register is in place which includes the name of the complainant, date the complaint was received, the date the complaint was responded to, and the date the complaint was closed. Evidence relating to the investigation of the complaint is included in the register. Interview with the FM and a review of complaints received outlined that the complaints process was inconsistently completed. Examples of information missing included, dates the acknowledgement letters had been sent to the complainant, date when the complaint had been closed, and the information that provided evidence that the complainant was satisfied with the outcome.</p> <p>Interviews with the FM, staff, residents, and whānau confirmed that they were aware of the complaints process and were encouraged to raise any concerns and provide feedback.</p> <p>The provider can access appropriate support for Māori residents via Te Whatu Ora Waitaha Canterbury if required to navigate the complaints process.</p> <p>The FM advised there had been no complaints made to the Health and Disability Commission (HDC) since the last audit.</p>

<p><b>Subsection 2.1: Governance</b></p> <p>The people: I trust the people governing the service to have the knowledge, integrity, and ability to empower the communities they serve.</p> <p>Te Tiriti: Honouring Te Tiriti, Māori participate in governance in partnership, experiencing meaningful inclusion on all governance bodies and having substantive input into organisational operational policies.</p> <p>As service providers: Our governance body is accountable for delivering a highquality service that is responsive, inclusive, and sensitive to the cultural diversity of communities we serve.</p>	<p>FA</p>	<p>The Ultimate Care Bishop Selwyn facility is part of Ultimate Care Group (UCG) which is a registered New Zealand company. There is a governance structure in place which monitors compliance with legislative, contractual, and regulatory requirements. An executive team provides direction to the facility.</p> <p>The annual strategic, business plan, has key outcomes which are resident centred, such as resident satisfaction, health and safety, complaints, education, and fiscal stability. These are monitored at board meetings. There is Māori representation at governance level, providing guidance to the organisation to ensure the necessary actions are embedded across the organisation that enacts the principles of the Te Tiriti. The national relationship manager has advised the core competencies that executive management are required to demonstrate including understanding the organisations obligations under Te Tiriti o Waitangi, health equity, and cultural safety. Review of previous resident and whanau survey results evidenced that the organisation values and prioritises input into service delivery from people receiving care.</p> <p>The organisation has a documented strategy plan incorporating vision, mission, and values statements. The document is reviewed annually by the executive team and the board. The organisations values were displayed in the facility and were included within information available to residents and whānau.</p> <p>The Māori health action plan describes how the organisation is aware of the barriers and inequities for Māori and work to reduce them. The FM described how staff are encouraged to learn basic te reo Māori phrases and continue to upskill in Māori tikanga. Whānau are encouraged to have input into service improvement as confirmed by staff, residents and whānau and review of resident meeting minutes.</p> <p>The UCG executive management team has a clinical governance structure in place that is appropriate to the size and complexity of the organisation. The clinical operations group (COG) report to the board monthly on key aspects of service delivery.</p> <p>The FM has a background in people management and reports to the regional manager (RM) who oversees the facility's quality and</p>

		<p>operational performance. The RM holds weekly video meetings with all facility/nurse managers in the region and maintains face to face contact. The clinical coach for the region provides clinical support.</p> <p>The organisation has implemented robust systems to support the quality and risk management structure with a wide range of information gathered to inform service delivery. The senior leadership team provides the necessary resources, keeping staff informed and providing support as evidenced by staff interviews.</p> <p>The Māori Health Action Plan outlines the organisations commitment to improving outcomes for tāngata whaikaha with the goals and actions required outlined, and support required to achieve aspirations and reduce barriers. The organisation continues to focus on the need to prioritise the building of partnerships with Māori disability stakeholders however partnerships were not in place with local iwi and Māori organisations (see 1.1.5).</p> <p>The provider holds contracts with Te Whatu Ora Waitaha Canterbury to deliver rest home, hospital, chronic health conditions, support care, and end of life support care medical illness services.</p> <p>The facility is certified to provide care for up to 78 residents, with all those beds able to accommodate both rest home and hospital residents. The facility has 72 studio units for which residents purchase an occupational right agreement (ORA). The provider has approval for subsidised care in the studio units. On the days of audit there were 59 residents receiving care, 30 of which were in the rest home and 29 in the hospital wing.</p>
<p>Subsection 2.2: Quality and risk</p> <p>The people: I trust there are systems in place that keep me safe, are responsive, and are focused on improving my experience and outcomes of care.</p> <p>Te Tiriti: Service providers allocate appropriate resources to specifically address continuous quality improvement with a focus on achieving Māori health equity.</p> <p>As service providers: We have effective and organisation-wide</p>	<p>FA</p>	<p>The organisation has an annually reviewed, executive team approved, quality and risk management plan. The plan outlines the identified internal and external organisational risks and the quality framework utilised to promote continuous quality improvement. There are policies, procedures, and associated systems to ensure that the organisation meets accepted good practice and adheres to relevant standards relating to the Health and Disability Services (Safety) Act 2001.</p> <p>There is an implemented annual schedule of internal audits. Areas of</p>



<p>governance systems in place relating to continuous quality improvement that take a risk-based approach, and these systems meet the needs of people using the services and our health care and support workers.</p>		<p>non-compliance include the implementation of a corrective action plan with sign off by the FM when completed. Identified trends are monitored and raised for discussion within the quality meetings. A reporting called the “managers reflective report” captures a broad range of clinical information across all facilities.</p> <p>The FM takes overall responsibility for health and safety within the facility. The provider has made a commitment to ensuring all staff are aware of the importance of health and safety and incorporate additional staff training to the training schedule.</p> <p>The provider holds a comprehensive schedule for staff meetings that includes but is not limited to quality, health and safety, staff, infection prevention, with a high staff attendance evident in meeting records reviewed. Meetings follow a set agenda with a broad range of topics discussed. At interview, and review of resident meeting minutes, it was noted that residents are involved in decision making/choices.</p> <p>The organisation follows the UCG National Adverse Event Reporting policy for external and internal reporting. The FM outlined that section 31 notifications had been sent to HealthCERT for the appointment of the FM, staffing shortages in 2022 (not required for 2023 thus far), one pressure area, and two minor abscondments.</p> <p>The organisation’s commitment to providing high quality health care and equity for Māori is stated within the Māori Health Action plan and policy. This includes the provision of appropriate education for staff, supporting leaders to champion high quality health care and ensuring that resident centred values guide clinical decision making. The organisations progress in these domains is closely followed at executive and Board level and improvements made when progress is less than optimal.</p>
<p>Subsection 2.3: Service management</p> <p>The people: Skilled, caring health care and support workers listen to me, provide personalised care, and treat me as a whole person.</p> <p>Te Tiriti: The delivery of high-quality health care that is culturally responsive to the needs and aspirations of Māori is achieved</p>	<p>FA</p>	<p>The organisations staffing policy includes the rationale for staff rostering and skill mix inclusive of a facility managers roster allocation to ensure staffing is maintained at a safe level. At the time of audit, the facility was fully staffed. Review of rosters evidenced that unplanned staff absences were covered appropriately by staff picking up additional shifts. The FM, clinical services manager (CSM) and some registered nurses (RN)</p>

<p>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.</p>		<p>provide an afterhours on call support.</p> <p>Seven RNs have completed InterRAI training with one more about to complete the training. The training schedule sampled evidenced that most care givers had completed or were about to complete the Careerforce training to level four.</p> <p>The FM and CSM work 40 hours per week. Laundry and cleaning staff are rostered seven days per week. The morning shift comprises of two RNs, two shift lead senior care givers (level four), and seven care givers. The afternoon shift comprises of one RN, one enrolled nurse (EN) or senior shift lead, two level four care givers and five care givers. The night shift comprises of one RN and three care givers.</p> <p>There is an implemented annual training programme. Staff competencies, training and education scheduled are relevant to the needs of aged care residents. The attendance records were sighted with the FM and CSM taking responsibility for ensuring all staff attend training as required. Current cultural safety training schedule provides staff with resources to support their practice and achieve equitable health outcomes.</p> <p>The provider is not responsible for the registration of national health index (NHI).</p> <p>The provider collects both staff and resident ethnicity data via the online platform and forms part of the monthly report compiled for the Board. Support systems promote staff wellbeing, and a positive work environment was confirmed in staff interviews. Employee support services are available as required.</p>
<p>Subsection 2.4: Health care and support workers</p> <p>The people: People providing my support have knowledge, skills, values, and attitudes that align with my needs. A diverse mix of people in adequate numbers meet my needs.</p> <p>Te Tiriti: Service providers actively recruit and retain a Māori health workforce and invest in building and maintaining their capacity and capability to deliver health care that meets the needs of Māori.</p>	<p>FA</p>	<p>The human resource management system follows policies and procedures 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 maintained. The recruitment process includes police vetting, reference checks, and validation of annual practising certificates/qualifications. Current practising certificates were sighted for those staff and contractors that require these. Job descriptions include</p>

<p>As service providers: We have sufficient health care and support workers who are skilled and qualified to provide clinically and culturally safe, respectful, quality care and services.</p>		<p>accountabilities/responsibilities specific to the role with a clear outline of who they report to. Personnel involved in driving the van used for resident outings held current drivers' licences and first aid certificates. Nonclinical staff include household and laundry personnel, part time maintenance person and kitchen staff.</p> <p>There is documented and implemented orientation programme and staff training records show that education is attended. There was recorded evidence of staff receiving orientation covering the essential components of service delivery with specifics relating to their roles included. Staff confirmed completing this and advised it was appropriate to their role. There is a separate policy and plan that outlines the orientation of agency staff. Staff files sampled evidenced that staff had completed annual performance reviews, and documentation was complete and current.</p> <p>Information held about health care and support workers is kept in a secure location with confidentiality maintained. Staff interview and review of documentation evidenced that staff ethnicity data is collected, and a review of staff records provided additional evidence that this was in place.</p> <p>Management ensure opportunities are provided for staff to be involved in a debrief discussion following significant events and can provide support as required.</p>
<p>Subsection 2.5: Information</p> <p>The people: Service providers manage my information sensitively and in accordance with my wishes.</p> <p>Te Tiriti: Service providers collect, store, and use quality ethnicity data in order to achieve Māori health equity.</p> <p>As service provider: We ensure the collection, storage, and use of personal and health information of people using our services is accurate, sufficient, secure, accessible, and confidential.</p>	<p>FA</p>	<p>Residents' records and medication charts are managed electronically. Residents' information including progress notes is entered into the residents' records 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.</p> <p>There are policies and procedures in place to ensure the privacy and confidentiality of resident information. Staff confirmed awareness of their obligations to maintain confidentiality of all resident information. Resident care and support information can be accessed in a timely manner and is protected from unauthorised access.</p> <p>Records include information obtained on admission and information</p>

		<p>supplied from resident's whānau where applicable. The clinical records are integrated, including information such as medical notes, assessment information, and reports from other health professionals.</p>
<p>Subsection 3.1: Entry and declining entry</p> <p>The people: Service providers clearly communicate access, timeframes, and costs of accessing services, so that I can choose the most appropriate service provider to meet my needs.</p> <p>Te Tiriti: Service providers work proactively to eliminate inequities between Māori and non-Māori by ensuring fair access to quality care.</p> <p>As service providers: When people enter our service, we adopt a person-centred and whānau-centred approach to their care. We focus on their needs and goals and encourage input from whānau. Where we are unable to meet these needs, adequate information about the reasons for this decision is documented and communicated to the person and whānau.</p>	<p>FA</p>	<p>On enquiry, an information booklet detailing entry criteria is provided to prospective residents and their whānau. This information is also available on the internet.</p> <p>On admission residents and their whānau are provided with written and verbal information with any questions raised answered by staff. Admission packs provide comprehensive information. The information is available in multiple languages, written in plain language citing key messages. Interpreters are available and used as required to ensure resident understanding is achieved. Staff interviewed reported they could access interpreter services if required.</p> <p>There are documented entry policies and processes in place and staff interviewed were able to discuss these in detail. Review of residents' files confirmed that entry to service complied with entry criteria. Information relating to admission, discharge and decline rates is analysed by the board via the monthly reporting system.</p> <p>Residents and whānau interviewed reported they were treated with respect throughout the admission process and understood the rationale for information required during the process, for example Enduring Power of Attorney (EPOA) status. They also confirmed that any questions raised were answered by staff in relation to admission, including waiting times.</p> <p>The service has a process in place if access is declined. It requires that when a person is declined access to the service, the person, their whānau and the referring agency are informed of the decline to entry. Alternative services when possible are offered and documentation of reason is maintained in internal files. A person would be declined entry if not within the scope of the service or if a bed was not available. The clinical services manager (CSM) explained that entry was declined for a person who had complex medical needs that could not be met as process and training for this condition had not been developed at the time admission was requested. Declining of admissions is reported as</p>

		<p>part of the UCG monthly report.</p> <p>The admission policy requires the collection of information that includes but is not limited to ethnicity; spoken language; interpreter requirements; iwi; hapu; religion; and referring agency. Interviews with residents and whānau 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, however the organisation has not yet established relationships with the iwi of the region including local Māori health providers, organisations, individuals, and communities to ensure appropriate support for tāngata whenua (refer finding 1.1.5).</p>
<p>Subsection 3.2: My pathway to wellbeing</p> <p>The people: I work together with my service providers so they know what matters to me, and we can decide what best supports my wellbeing.</p> <p>Te Tiriti: Service providers work in partnership with Māori and whānau, and support their aspirations, mana motuhake, and whānau rangatiratanga.</p> <p>As service providers: We work in partnership with people and whānau to support wellbeing.</p>	<p>FA</p>	<p>Ultimate Care Group has developed a model of care specific to older persons. Staff interviewed described the model of care and how the model informed care delivery. Resident care plans are developed using an electronic system. RNs are responsible for all residents' assessments, care planning and evaluation of care.</p> <p>Initial care plans are developed with the residents/next of kin/EPOA consent within the required timeframe. They are based on data collected during the initial nursing assessments and on information from pre-entry assessments completed by the needs assessment co-ordination service (NASC) or other referral agencies. The assessments include information about, but not limited to, the resident's medical history, pain, nutrition, mobility, skin condition, early warning signs (EWS), cultural needs, spiritual wellbeing, and documentation of the resident's life experience. Assessments sampled had been completed in consultation with the resident and whānau. Residents interviewed confirmed assessments are completed according to their needs and in the privacy of their bedrooms.</p> <p>The residents' activities assessments are completed by the diversional therapist (DT) in conjunction with the RN following 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/whānau and documented. The activity assessments include a cultural assessment which gathers information about cultural needs, values, and beliefs. Information from these assessments is used to develop the resident's individual activity care plan. The residents'</p>

	<p>activity needs are reviewed six monthly at the same time as the care plans and are part of the formal six-monthly multidisciplinary review process.</p> <p>The individualised long term care plans (LTCPs) are developed with information gathered during the initial assessments and from the interRAI assessment. Documented interventions and early warning signs meet the residents' assessed needs. Short term care plans are developed for acute problems for example infections, pain, or post-fall care.</p> <p>A general practitioner (GP) visits the facility weekly. The initial medical assessment is completed by the 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. The GP interviewed confirmed that there was good communication with the service, they were informed of concerns in a timely manner and instructions given were followed. The facility has access to an after-hours service. A physiotherapist visits the facility weekly and reviews residents referred by the CSM or RNs. A podiatrist visits the facility every six weeks.</p> <p>Staff interviewed and education records sighted confirmed that staff had completed cultural training. The provision of care reflected in the care plan is consistent with, and contributes to, meeting the residents assessed needs, goals, and aspirations. Support is identified for whānau. Staff discussed service provision to include providing services free from stigma and those which promote acceptance and inclusion.</p> <p>There was evidence of wound care products available. The review of the wound care plans evidenced wounds were assessed in a timely manner and reviewed at appropriate intervals. Photos were taken where this was required. Where wounds required additional specialist input, this was initiated.</p> <p>Nursing progress notes are recorded and maintained. Monthly observations such as weight and blood pressure were completed and are up to date. Neurological observations are recorded following all unwitnessed falls. Any changes in the resident's condition are documented. There are escalation processes in place for clinical change</p>
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		<p>and staff were able to discuss these. Clinical records sampled confirmed that where escalation had occurred as required this had been documented appropriately. Interviews with medical and nursing staff confirmed the process was undertaken consistently.</p> <p>Policies and protocols are in place to ensure continuity of service delivery. Staff interviews confirmed they are familiar with the needs of all residents and that they have access to the supplies and products they require.</p> <p>Resident care is evaluated on each shift, 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 when 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. The clinical records sampled demonstrated that reviews of the resident care were ongoing. Handover meetings between each shift ensure residents progress towards meeting identified goals is discussed. Where progress is different from that expected, changes to the resident's care plan are made and actions implemented. This was verified in clinical files sampled and during staff and resident interviews.</p> <p>The organisation has developed policies and procedures in conjunction with the other relevant services and organisations to support tāngata whaikaha. These services and organisations had representation from tāngata whaikaha. Interviews with staff confirmed that staff were able to facilitate tāngata whaikaha access to information should this be required.</p> <p>A Māori health care plan is used for residents identifying as Māori. The care plan guides staff in gathering information and documenting the support required to meet the Māori resident's needs. Staff discussed their understanding of support required for Māori and whānau to identify their own pae ora outcomes in their care or support plan, how these could be achieved and documented.</p>
<p>Subsection 3.3: Individualised activities</p> <p>The people: I participate in what matters to me in a way that I</p>	<p>FA</p>	<p>The residents' activities programme is developed and implemented a diversional therapist (DT) and two activities co-ordinators. There are separate programmes for the hospital, rest home and for the residents</p>

<p>like.</p> <p>Te Tiriti: Service providers support Māori community initiatives and activities that promote whanaungatanga.</p> <p>As service providers: We support the people using our services to maintain and develop their interests and participate in meaningful community and social activities, planned and unplanned, which are suitable for their age and stage and are satisfying to them.</p>		<p>who live in the studio units. There are some shared activities and there is provision for residents to attend activities in different areas if desired. Activities for the residents are provided Monday to Friday. At weekends movies, puzzles and quizzes and other activities are available. The activities programme is displayed in the communal area and on the individual resident notice boards. The 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 diversional therapist or activity co-ordinators occur regularly.</p> <p>Church services are held weekly. Weekly van outings into the community are arranged for both hospital and rest home residents.</p> <p>The programme is culturally diverse and tailored to the needs of the residents. Activities for the residents have included visits from kapa haka groups, Waitangi Day and Matariki celebrations, entertainers singing Māori songs, visits from a Māori youth group and Māori craft sessions. The facility has developed links to a local kindergarten; residents visit the kindergarten regularly and have afternoon tea and read with the children. Whānau participation in the programme is encouraged. Staff interviews confirmed that they had completed Māori cultural awareness education and that the involvement of Māori residents in the delivery of services is encouraged.</p> <p>Regular resident meetings are held and include discussion around activities. The residents and whānau reported satisfaction with the activities provided. Over the course of the audit residents were observed engaging and enjoying a variety of activities.</p>
<p>Subsection 3.4: My medication</p> <p>The people: I receive my medication and blood products in a safe and timely manner.</p> <p>Te Tiriti: Service providers shall support and advocate for Māori to access appropriate medication and blood products.</p> <p>As service providers: We ensure people receive their medication and blood products in a safe and timely manner that complies with current legislative requirements and safe practice</p>	<p>FA</p>	<p>A current medication management policy identifies all aspects of medicine management in line with relevant legislation, standards, and guidelines. A safe system for medicine management using an electronic system was observed. Prescribing practices are in line with legislation, protocols, and guidelines. The required three-monthly reviews by the GP were recorded electronically. Resident allergies and sensitivities are documented on the electronic medication chart and in the resident's electronic record.</p>



<p>guidelines.</p>	<p>The service uses pharmacy pre-packaged medicines that are checked by the RN on delivery. There is a supply of stock medication which is used for hospital level residents. Stock medications sighted were within current use by dates. A system is in place for returning expired or unwanted medication. The medication refrigerator temperatures and medication room temperatures are monitored as per UCG policy and are within the required range.</p> <p>Controlled medications are stored securely in accordance with requirements. Controlled medications are checked by two staff for accuracy in administration. Weekly checks of medications and six monthly stocktakes are conducted in line with policy and legislation.</p> <p>The staff observed administering medication demonstrated knowledge and at interview demonstrated clear understanding of their roles and responsibilities related to each stage of medication management. The RN oversees the use of all 'as required' (PRN) medications and documentation made regarding effectiveness was sighted.</p> <p>Current medication competencies were evident in staff files. Education for residents regarding medications occurs on a one-to-one basis by the GP, CSM or RN. Medication information for residents and whānau can be accessed from the contracted pharmacy and from Medsafe as needed.</p> <p>Two residents were self-administering medication. The residents' clinical files were reviewed, the residents and an RN interviewed. The residents' medication files confirmed self-administration. Staff check during medication rounds to ensure medication has been administered as required and this is documented. Self-administration competency documentation was sighted, these were current and signed by the residents and GP. The residents have a lockable box in their bedroom for storage of medication, this was observed. The residents confirmed satisfaction with the self-administration process.</p> <p>There are no standing orders in place.</p> <p>The UCG medication policy describes use of over the counter (OTC) medications and traditional Māori medications and the requirement for these to be discussed with, and approved by, a medical practitioner. Interview with the GP, CSM and RN confirmed that where over the counter or alternative medications were being used, they were added to</p>
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		<p>the medication chart following discussion with the resident and/or their whānau. The GP confirmed if a Māori resident wished to use complementary Māori medications this would be discussed with the resident and their whānau prior to approval being given.</p>
<p>Subsection 3.5: Nutrition to support wellbeing</p> <p>The people: Service providers meet my nutritional needs and consider my food preferences.</p> <p>Te Tiriti: Menu development respects and supports cultural beliefs, values, and protocols around food and access to traditional foods.</p> <p>As service providers: We ensure people's nutrition and hydration needs are met to promote and maintain their health and wellbeing.</p>	<p>FA</p>	<p>A nutritional assessment is undertaken by an RN for each resident on admission to identify dietary requirements, allergies / sensitivities, 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 confirmed awareness of the dietary needs, allergies/ sensitivities, likes and dislikes of residents. These are accommodated in daily meal planning.</p> <p>All meals are prepared on site and served in the dining rooms or in the residents' rooms as requested. Residents can participate in food preparation as part of the activity programme and a breakfast club has recently been instigated where residents can choose from a range of breakfast options available and can access these independently to eat with other residents in the dining room. The temperature of food served is 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.</p> <p>The food service is provided in line with recognised nutritional guidelines for older people. The seasonal menu has been approved by a New Zealand Registered Dietician. The food control plan expiry date is June 2024.</p> <p>The kitchen was observed to be clean, and the cleaning schedules sighted. All aspects of food procurement, production, preparation, storage, delivery, and disposal sighted at the time of the audit 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 and labelled 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.</p>

		<p>Discussion and feedback on the menu and food provided is sought at the residents' meetings and in the annual residents' survey. For Māori residents' information is gathered regarding nutritional needs and preferences during the initial assessment and during the development of their individual Māori health plan. The cook explained that Māori residents can request special diets, this was confirmed in staff interviews.</p>
<p>Subsection 3.6: Transition, transfer, and discharge</p> <p>The people: I work together with my service provider so they know what matters to me, and we can decide what best supports my wellbeing when I leave the service.</p> <p>Te Tiriti: Service providers advocate for Māori to ensure they and whānau receive the necessary support during their transition, transfer, and discharge.</p> <p>As service providers: We ensure the people using our service experience consistency and continuity when leaving our services. We work alongside each person and whānau to provide and coordinate a supported transition of care or support.</p>	<p>FA</p>	<p>There are policies and processes that guide the transition, transfer, and discharge of residents. Staff interviewed were aware of the procedures required and discussed these during the audit.</p> <p>Records reviewed evidenced that transition, exit, discharge, or transfer is managed in a planned and coordinated manner and includes ongoing consultation with residents and whānau. The service facilitates access to other medical and non-medical services. Residents and/or whānau are advised of options to access other health and disability services, social support or Kaupapa Māori agencies if indicated or requested.</p> <p>Staff interviewed were able to discuss other health and disability services and/or social support agencies that were suitable for the residents. Brochures were displayed that provided information about a range of community health and social support agencies. When needed, referrals are sent to ensure other health services, including specialist care is provided. Referral forms and documentation are maintained on resident files. Referrals are regularly followed up. Communication records sampled, confirmed whānau are kept informed of the referral process.</p> <p>Interview with the CSM and review of residents' files confirmed there is open communication between services, the resident, and whānau. Relevant information is documented and communicated to health providers. For residents who are discharged into the community discharge documentation is tailored to the individual circumstances and can include a medication chart and a care summary generated by the electronic system. For transfers to another service or facility the 'yellow envelope' system is used, documentation includes a transfer form, medication chart and care summary.</p>

<p><b>Subsection 4.1: The facility</b></p> <p>The people: I feel the environment is designed in a way that is safe and is sensitive to my needs. I am able to enter, exit, and move around the environment freely and safely.</p> <p>Te Tiriti: The environment and setting are designed to be Māori-centred and culturally safe for Māori and whānau.</p> <p>As service providers: Our physical environment is safe, well maintained, tidy, and comfortable and accessible, and the people we deliver services to can move independently and freely throughout. The physical environment optimises people's sense of belonging, independence, interaction, and function.</p>	<p>FA</p>	<p>The building warrant of fitness was current until July 2024. Buildings, plant, and equipment comply with the legislation relevant to the service being provided. A preventative and reactive maintenance schedule is implemented. This includes monthly checks of all areas and specified equipment such as hoists. Staff identify maintenance issues via an electronic system. This information is reviewed by the maintenance person and prioritised. Staff confirmed awareness of the process for maintenance requests and confirmed that repairs were conducted in a timely manner. The maintenance person works in tandem with the FM to ensure hazards are identified, documented in the hazard register, and reviewed. The FM maintains responsibility for ensuring the register is current.</p> <p>Interviews with staff and visual inspection confirmed there was adequate equipment available to support care. The facility has an up-to-date electrical testing and tagging programme. The schedule for checking and calibration of bio-medical equipment was sighted. There is a system to ensure the facility van is routinely maintained. The van has a current registration, warrant of fitness, and first aid kit. The van is not fitted with a hoist and residents who use a wheelchair are transported via mobility taxi. Staff interviews and documentation evidenced that those who drive the van have a current driver's licence and first aid certificate.</p> <p>Interview with the FM in the absence of the maintenance person confirmed a system is in place that records the temperature of the hot water across the facility at regular intervals. Anomalies are managed by the maintenance person who informs the FM as required.</p> <p>All areas can be accessed with mobility aids. There are accessible external areas for residents and their visitors that provide shade and seating. There were sufficient toilet facilities available for residents and visitors. All communal toilets had a system to indicate vacancy and provide disability access. All showers and toilet facilities have call bells, sufficient room, approved handrails, and other equipment to facilitate ease of mobility and promote safety and independence.</p> <p>Residents have their own room, and each is of sufficient size to allow residents to mobilise safely around their personal space and bed area</p>

		<p>with mobility aids and/or assistance. Observations and interviews with staff evidenced that space for hoists, wheelchairs, and walking frames is adequate.</p> <p>All resident's rooms and communal areas accessed by residents are ventilated with at least one external window providing natural light. Resident rooms were heated in the winter and cooled in the summer. The environment in resident areas was noted to be maintained at a satisfactory temperature. This was confirmed by staff, residents, and whānau.</p> <p>Staff interview confirmed that in the event of additions to the facility Māori consultation would be accessed with the support of UCG head office.</p>
<p>Subsection 4.2: Security of people and workforce</p> <p>The people: I trust that if there is an emergency, my service provider will ensure I am safe.</p> <p>Te Tiriti: Service providers provide quality information on emergency and security arrangements to Māori and whānau.</p> <p>As service providers: We deliver care and support in a planned and safe way, including during an emergency or unexpected event.</p>	<p>FA</p>	<p>There was a suite of policies and procedures related to the management of emergencies. Staff confirmed they were familiar with these and described their role in the event of an emergency. Induction of new staff included training in fire and emergency procedures, and staff files sampled confirmed this had been completed. Fire drills and emergency evacuations were completed at least six monthly with the last one completed three months prior to the audit. Emergency exit doors were signposted throughout the facility. These were noted to be free from obstruction.</p> <p>The evacuation plan had been approved by Fire and Emergency New Zealand. Fire extinguishers were strategically placed throughout the facility and had been checked within the last 12 months by a contracted service.</p> <p>Residents and whānau were advised of the facilities emergency responses on admission. The FM explained the expected emergency response to the audit team at the beginning of the audit process. Emergency flipcharts and floor plans were located at prominent locations in each wing. Each shift had at least one staff member with a current first aid certificate. This was confirmed by education records and staff rosters.</p> <p>Battery operated lighting was utilised in the event of a power failure, with</p>

		<p>multiple torches on hand to provide additional lighting. In the event of a prolonged power outage the facility had a contract with a service that ensured the facility had priority accessing a generator. Civil defence kits were sighted. The supply of emergency food and water on site was noted to be sufficient for a minimum of three days.</p> <p>There was a call bell in each resident's bedroom, and all bathrooms. Other call bells were placed strategically throughout the facility. Three personal pendant alarms were available and allocated to residents who required them.</p> <p>A local security service was contracted to provide security patrols overnight. A community watch service provided additional patrols each evening. The main entry door utilised a double door system and staff controlled who entered the facility after hours. Additional security measures included visitors signing in and out, staff wearing the organisations uniforms and name badges, and security lighting.</p>
<p><b>Subsection 5.1: Governance</b></p> <p>The people: I trust the service provider shows competent leadership to manage my risk of infection and use antimicrobials appropriately.</p> <p>Te Tiriti: Monitoring of equity for Māori is an important component of IP and AMS programme governance.</p> <p>As service providers: Our governance is accountable for ensuring the IP and AMS needs of our service are being met, and we participate in national and regional IP and AMS programmes and respond to relevant issues of national and regional concern.</p>	<p>FA</p>	<p>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 prevention programme.</p> <p>The Ultimate Care Group senior leadership team (SLT) have as part of their senior management team personnel with expertise in IP and AMS. Expertise can also be accessed from "Bug Control" who supply the UCG with infection control resources.</p> <p>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.</p> <p>Policies and procedures are in place to manage IP. Significant IP events are managed using a stepwise approach to risk management and receive the appropriate level of organisational support.</p> <p>External resources and support are available through external specialists, microbiologist, GP, wound clinical nurse specialist and Te Whatu Ora Canterbury when required. Overall effectiveness of the</p>

		programme is monitored by the CSM.
<p>Subsection 5.2: The infection prevention programme and implementation</p> <p>The people: I trust my provider is committed to implementing policies, systems, and processes to manage my risk of infection. Te Tiriti: The infection prevention programme is culturally safe. Communication about the programme is easy to access and navigate and messages are clear and relevant. As service providers: We develop and implement an infection prevention programme that is appropriate to the needs, size, and scope of our services.</p>	FA	<p>The infection 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. The UCG clinical operations group (COG) involve staff at site level in the review of policies and procedures and the infection prevention and control nurse (IPCN) has input when IP policies and procedures are reviewed.</p> <p>The CSM is the IPCN. They have attended training for the role. A documented and signed role description for the IPCN was sighted. The IPCN reports to the regional manager and the clinical coach. The IPCN is supported by the infection control committee which consists of the FM and representatives from all work areas. Infection control reports are discussed at the facility's quality meetings. The IPCN 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.</p> <p>Policies and procedures 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. Single use medical devices are not reused. Cleaning and laundry management policies are in place.</p> <p>Infection prevention and control resources including personal protective equipment (PPE) are available should a resident infection or outbreak occur. Observation confirmed these are used appropriately including masks, aprons, and gloves. There are ample reserves onsite and a system in place if additional stock is required. The FM and IPCN have responsibility for purchasing equipment/resources for infection prevention in collaboration with the national office. Staff were observed to be complying with the infection control policies and procedures. Staff</p>

	<p>demonstrated knowledge on the requirements of standard precautions and were able to locate policies and procedures.</p> <p>The IPCN 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. Staff have completed infection control education in the last 12 months. The IPCN has access to an online training system with resources, guidelines, and best practice. Infection control audits have been completed. There is a process to review outcomes and audit compliance. Audit outcomes are benchmarked against other UCG facilities, and this information is available to the facility staff and to the board. Compliance with the audit schedule was confirmed through review of records and benchmarking data provided.</p> <p>Infection prevention input into new buildings or significant changes occurs at local and national level and involves the FM and the senior leadership team.</p> <p>The outbreak and the pandemic plans have been implemented successfully during the COVID-19 pandemic and have been reviewed and tested at regular intervals. Two COVID-19 outbreaks have occurred since the previous onsite audit. The documentation reviewed confirmed these were managed to meet policy and contract requirements. Debriefing meetings were completed. Required reporting for outbreaks was completed including section 31 reporting and this was confirmed onsite through interview and document review.</p> <p>A range of interventions have occurred in relation to COVID-19 including visitor testing as required. Processes continue to be reviewed and changed in line with current accepted practice and national guidelines with different variants emerging including the national staff testing programme. Hand sanitisers and gels are available for staff, residents, and visitors to the facility. COVID-19 information is available to all visitors to the facility.</p> <p>Education for residents, including Māori, 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. Educational resources in te reo Māori are available and an</p>
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		interpreter can be accessed if needed.
<p>Subsection 5.3: Antimicrobial stewardship (AMS) programme and implementation</p> <p>The people: I trust that my service provider is committed to responsible antimicrobial use.</p> <p>Te Tiriti: The antimicrobial stewardship programme is culturally safe and easy to access, and messages are clear and relevant.</p> <p>As service providers: We promote responsible antimicrobials prescribing and implement an AMS programme that is appropriate to the needs, size, and scope of our services.</p>	FA	<p>An antimicrobial stewardship programme (AMS) is in place. The AMS programme is developed and implemented to optimise antimicrobial use and to minimise harm. There are approved policies and guidelines for antimicrobial prescribing.</p> <p>Infection prevention and control data is collected and analysed. Once submitted it includes all surveillance data such as the infection management system and AMS surveillance outcomes alongside audits for infections. The medication management system captures surveillance data on antibiotic prescribing, allergies/sensitivities for the AMS programme. Staff outlined how cultural advice is accessed when indicated to ensure the IPC programme remains culturally safe. All new staff receive induction/orientation including infection prevention and this is available on-line. The ICPN provides planned and opportunistic education for staff.</p> <p>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. The effectiveness of the AMS programme is continually evaluated, and any areas identified for improvement are actioned. Reporting including analysed data is included in the monthly quality report through to the board. Staff were informed about antibiotic prescribing and the relationship to the increase of multi drug resistant organisms.</p>
<p>Subsection 5.4: Surveillance of health care-associated infection (HAI)</p> <p>The people: My health and progress are monitored as part of the surveillance programme.</p> <p>Te Tiriti: Surveillance is culturally safe and monitored by ethnicity.</p> <p>As service providers: We carry out surveillance of HAIs and multi-drug-resistant organisms in accordance with national and</p>	PA Low	<p>Surveillance is an integral part of the infection control programme. The surveillance undertaken is detailed in the infection prevention and control programme. This includes monitoring positive results for infections and outbreaks. The purpose and methodology are described in the UCG surveillance policy. The FM and the ICPN use the information obtained through surveillance to determine infection control activities, resources, and education needs.</p> <p>Monthly infection data is collected for all infections based on standard</p>

<p>regional surveillance programmes, agreed objectives, priorities, and methods specified in the infection prevention programme, and with an equity focus.</p>		<p>definitions, however not all required detail was included in the data collection or reporting. 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 quality meetings. Meeting minutes are available to all staff. Variances in trends in surveillance data are identified and investigated as verified during interview. Results of surveillance are discussed and reported to clinical governance as required.</p> <p>Residents who developed an infection were informed and family/whānau were advised. Culturally safe communication processes are outlined within the Māori Health Plan for residents with healthcare associated infections (HAI).</p> <p>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 residents with an infection. There are processes in place to isolate infectious residents when required.</p> <p>Monthly surveillance data is collected and reported to the executive team, Trends, and opportunities to improve are considered by the CSM, and the national clinical services manager. There were no trends identified in IPC documents sampled. The reports were discussed at staff meetings, and this was verified by staff. The GP stated the service cared for residents in a manner that reduced the rate of infection, and any residents with signs and symptoms of infection were reviewed in a timely manner.</p>
<p>Subsection 5.5: Environment</p> <p>The people: I trust health care and support workers to maintain a hygienic environment. My feedback is sought on cleanliness within the environment.</p> <p>Te Tiriti: Māori are assured that culturally safe and appropriate decisions are made in relation to infection prevention and environment. Communication about the environment is culturally safe and easily accessible.</p> <p>As service providers: We deliver services in a clean, hygienic</p>	<p>FA</p>	<p>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; disposal of general, infectious, and hazardous waste.</p> <p>Current material safety data information sheets are available and accessible to staff in relevant places, such as the laundry and the sluice room. Staff complete a chemical safety training module on orientation.</p>

<p>environment that facilitates the prevention of infection and transmission of antimicrobial resistant organisms.</p>	<p>Staff receive training and education in waste management and infection control as a component of the mandatory training. Yellow containers for sharps and syringes were viewed in clinical areas. The processes to manage these were confirmed.</p> <p>Interviews and observations confirmed that there is enough PPE and equipment provided, such as aprons, gloves, and masks. Interviews confirmed that the use of PPE is appropriate to the recognised risks. Observation confirmed that PPE was used in high-risk areas.</p> <p>Laundry and cleaning services are provided seven days a week. Some laundry is outsourced and collected Monday to Friday. At the weekends laundry to be collected is stored in the garage. Sampled rosters confirmed that cleaning and laundry duties are rostered part time each day. Caregivers on afternoon and night shifts complete any laundry tasks required. Visual inspection of the laundry demonstrated the implementation of a clean/dirty process for the hygienic washing, drying, and handling of personal clothes and linen. The safe and hygienic collection and transport of laundry items into relevant labelled containers was witnessed. Laundry personnel interviewed demonstrated knowledge of the process to handle and wash infectious items. Laundry audits are completed. Clean linen is stored appropriately in hall cupboards with linen trolleys covered when in use. 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.</p> <p>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. Housekeeping 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.</p> <p>There is policy to provide direction and guidance to safely reduce the risk of infection during construction, renovation, installation, and maintenance activities. It details consultation by the infection control team. There was no construction, installation, or maintenance in</p>
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		progress at the time of the audit.
<p>Subsection 6.1: A process of restraint</p> <p>The people: I trust the service provider is committed to improving policies, systems, and processes to ensure I am free from restrictions.</p> <p>Te Tiriti: Service providers work in partnership with Māori to ensure services are mana enhancing and use least restrictive practices.</p> <p>As service providers: We demonstrate the rationale for the use of restraint in the context of aiming for elimination.</p>	FA	<p>There are policies, procedures, and processes in place to guide practice related to the use of restraint. The organisation has a restraint philosophy aimed towards a restraint free environment. All restraint practice is managed through an established process consistently across all Ultimate Care Group facilities.</p> <p>When restraint is considered, the decision-making escalation process requires input from the national restraint team including the lead clinician. Staff interviews confirmed the organisations approach to the elimination of restraint and management of behavioural challenges through alternative means. Falls risks were highlighted as part of this approach and outcomes considered along with other alternatives. The safety of residents and staff is always considered by the restraint team, and this was discussed.</p> <p>Records confirmed the completion of restraint minimisation and safe restraint use training with annual updates completed. Staff reported they were trained and competent to manage challenging behaviour, documentation confirmed this.</p> <p>Staff interviewed confirmed the processes that are required for Māori residents when considering restraint or if restraint practice is implemented. Discussion included staff commitment to ensuring the voice of people with lived experience, there are processes in place to ensure Māori/whānau oversight is provided.</p> <p>Executive leaders receive restraint reports monthly alongside aggregated restraint data, including the type and frequency of restraint if restraint has occurred. This forms part of the regular reflection report to the board.</p> <p>There are no episodes of restraint recorded since the last audit. Restraint is only considered a last resort.</p>

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.1.5</p> <p>My service provider shall work in partnership with iwi and Māori organisations within and beyond the health sector to allow for better service integration, planning, and support for Māori.</p>	PA Low	Discussion with the facility manager and review of documentation evidenced that a partnership is yet to be formalised with local iwi and Māori organisations.	The provider is yet to develop a formal partnership with iwi and Māori organisations.	<p>The provider is to develop a formal partnership with iwi and Māori organisations within and beyond the health sector to allow for better service integration, planning and support for Māori.</p> <p>180 days</p>
<p>Criterion 1.2.5</p> <p>My service provider shall work in partnership with Pacific communities and organisations, within and beyond the health and disability sector, to enable better planning, support, interventions, research, and evaluation of the health and</p>	PA Low	Discussion with the FM outlined that formal partnership is yet to be established between the facility and Pacific communities/organisations.	The provider is yet to develop a formal partnership with Pacific communities/organisations.	<p>The provider is to develop a formal relationship with Pacific communities/organisations to enable better planning, support, interventions, and evaluation of the health and wellbeing of pacific peoples.</p> <p>180 days</p>

wellbeing of Pacific peoples to improve outcomes.				
<p>Criterion 1.8.3</p> <p>My complaint shall be addressed and resolved in accordance with the Code of Health and Disability Services Consumers' Rights.</p>	PA Low	Discussion with the FM and review of documentation evidenced that the provider has a system in place to manage complaints in accordance with UCG policies and procedures, however this was inconsistently completed.	The complaints register and process was inconsistently completed.	<p>Ensure that the complaints management system is consistently followed as per the organisation policy and procedure.</p> <p>90 days</p>
<p>Criterion 1.8.4</p> <p>I am informed of the findings of my complaint.</p>	PA Low	Discussion with the FM and review of documentation evidenced that the provider has a system in place to manage complaints in accordance with UCG policies and procedures however evidence that the complainant had been informed of the outcome was not always available.	The outcome for complaints was not consistently completed.	<p>Ensure that all complaints are completed as per policy and procedure.</p> <p>90 days</p>
<p>Criterion 5.4.3</p> <p>Surveillance methods, tools, documentation, analysis, and assignment of responsibilities shall be described and documented using standardised surveillance definitions. Surveillance includes ethnicity data.</p>	PA Low	Surveillance reports documented the residents name, national health index (NHI) number and other relevant data, however the resident's ethnicity was not included on the report.	Surveillance reports do not include the resident's ethnicity.	<p>Ensure surveillance reports include the resident's ethnicity.</p> <p>180 days</p>

## Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display
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End of the report.