Melody Enterprises Limited - Ultimate Care Rhapsody

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Melody Enterprises Limited
Premises audited:	Ultimate Care Rhapsody
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 3 October 2023 End date: 4 October 2023

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 56

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Ultimate Care Rhapsody is part of Ultimate Care Group Limited. It is certified to provide care for up to 72 residents requiring rest home or hospital level services. On day of audit 56 beds were occupied. The facility is managed by a facility manager, and a clinical services manager. The facility manager had been appointed since the last audit and had been in the role for twelve months. The clinical services manager was appointed two months ago. There have been no other changes to the organisation or within the facility.

This surveillance audit was conducted against the Ngā Paerewa Health and Disability Services Standards NZS8134:2021 and the providers contracts with Te Whatu Ora – Taranaki. The audit process included review of policies and procedures, review of resident and staff records, observations, and interviews with residents, whānau, staff, and a general practitioner.

Previous areas identified as requiring improvement related to communication, quality management systems and performance appraisals are now closed.

A previous area identified as requiring improvement relating to care plan evaluation remains open.

A previous area identified as requiring improvement related to service provider availability is partially closed.

Additional areas identified as requiring improvement relating to care planning, medication management, and infection 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.		Subsections applicable to this service fully attained.

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

Resident rights were respected and upheld in line with the Health and Disability Commission Code of Health and Disability Services Consumers' Rights (the Code). Residents received services in a manner that was responsive to and respected their individuality, dignity, privacy, and independence. The provider had a culture of open disclosure.

Care plans accommodated the choices of residents and their whānau.

Hunga mahi me te hanganga | Workforce and structure

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

Ultimate Care Group Limited is the governing body responsible for the services provided. The provider had a current business and quality and risk management plans. Quality and risk management systems were in place. Meetings were held that included

reporting on various clinical indicators, quality and risk issues, and the review of identified trends. A clinical services manager oversaw the clinical and care services. A regional manager supported the facility manager in their role.

There were human resource policies that guided practice in relation to recruitment, orientation, and management of staff. At the time of audit there was a significant national health workforce shortage. Findings in this audit relating to staff shortages should be read in context of this national shortage.

Ngā huarahi ki te oranga | Pathways to wellbeing

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

Registered nurses assessed residents on admission with input from the resident and/or whānau.

InterRAI assessments were used to identify residents' needs. The general practitioner completed a medical assessment on admission and reviews occurred thereafter on a regular basis.

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

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

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

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

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

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

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

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

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

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

Here taratahi | Restraint and seclusion

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

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

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Subsection	0	15	0	1	3	0	0
Criteria	0	45	0	1	4	0	0

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

Attainment against the Ngā Paerewa Health and Disability Services Standard

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

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

For more information on the standard, please click here.

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

Subsection with desired outcome	Attainment Rating	Audit Evidence
Subsection 1.1: Pae ora healthy futures Te Tiriti: Māori flourish and thrive in an environment that enables good health and wellbeing. As service providers: We work collaboratively to embrace, support, and encourage a Māori worldview of health and provide high-quality, equitable, and effective services for Māori framed by Te Tiriti o Waitangi.	FA	Staff receive training in cultural safety at orientation. The organisation had developed a cultural safety module that was provided as part of the mandatory annual education programme. It defined and explained cultural safety and its importance, including Te Tiriti o Waitangi and tikanga best practice. Staff interviewed outlined how they ensure that cultural safety and tikanga best practice is embedded in care delivery. Current staff had completed the training except staff who were completing orientation. The organisation had a Māori health action plan that recognised the principles of Te Tiriti o Waitangi and described how Ultimate Care Group (UCG) responded to Māori cultural needs in relation to self-determination, independence, and autonomy. Māori residents interviewed stated they were involved in decision making and care was respectful of their cultural needs. There were residents who identified as Māori residing in the facility at time of audit.

Subsection 1.2: Ola manuia of Pacific peoples in Aotearoa The people: Pacific peoples in Aotearoa are entitled to live and enjoy good health and wellbeing. Te Tiriti: Pacific peoples acknowledge the mana whenua of Aotearoa as tuakana and commit to supporting them to achieve tino rangatiratanga. As service providers: We provide comprehensive and equitable health and disability services underpinned by Pacific worldviews and developed in collaboration with Pacific peoples for improved health outcomes.	FA	The Pacific plan outlined the organisation's commitment to providing culturally safe care and defined the cultural and spiritual beliefs of Pacific peoples. The policy was underpinned by Pacific models of care with UCG senior staff accessing information to support the plan from Pacific communities. Further discussion with UCG staff involved in the creation of the Pacific plan provided examples of what was being implemented as a pilot in another facility for their Pacific residents.
Subsection 1.3: My rights during service delivery The People: My rights have meaningful effect through the actions and behaviours of others. Te Tiriti:Service providers recognise Māori mana motuhake (self-determination). As service providers: We provide services and support to people in a way that upholds their rights and complies with legal requirements.	FA	The Code of Health and Disability Services Consumers' Rights (the Code) was on display in each wing of the facility, written in English and te reo Māori. Education records confirmed that staff had completed training that covered the Code. Staff discussed the Code and provided examples of how they met the Code when providing day to day care. Observation during the audit confirmed that the provision of care was provided in accordance with the Code. Residents and whānau were provided written information about the Code on admission, and confirmed they were provided opportunities to discuss their rights.
Subsection 1.5: I am protected from abuse The People: I feel safe and protected from abuse. Te Tiriti: Service providers provide culturally and clinically safe services for Māori, so they feel safe and are protected from abuse. As service providers: We ensure the people using our services are safe and protected from abuse.	FA	There was policy that included definitions, guidelines, and responsibilities for staff to report alleged or suspected abuse. Staff received orientation and mandatory training in abuse and neglect. Interviews confirmed staff awareness of their obligations to report any incidences of suspected abuse. Staff and whānau interviews confirmed there was no evidence of abuse or neglect. The admission agreement signed prior to occupation provided clear expectations regarding management responsibilities of personal property and finances. Residents and/or their whānau provided consent for the administrator to manage residents' comfort funds. Staff interview and review of documentation evidenced that appropriate systems were in place that ensures the safe management of residents' comfort funds. Residents and/or their whānau provided further confirmation that residents' property

		was respected. Staff, resident, and whānau interviews evidenced that the provider promoted an environment that provided a safe place for all to raise questions or concerns and that discussions were free and open. Staff complete abuse and neglect training on commencement of employment.
Subsection 1.6: Effective communication occurs The people: I feel listened to and that what I say is valued, and I feel that all information exchanged contributes to enhancing my wellbeing. Te Tiriti: Services are easy to access and navigate and give clear and relevant health messages to Māori. As service providers: We listen and respect the voices of the people who use our services and effectively communicate with them about their choices.	FA	Review of incident and accident information, staff and whānau interviews evidenced that policy and process was adhered to following a resident having an unwitnessed fall. Communication with whānau was documented with whānau interviewed stating they receive notification in the event their relative has had an incident/accident, or their health status has changed. Neurological observations when required, had been completed as per policy. The previous area identified as requiring improvement relating to criterion 1.6.3 is now closed.
Subsection 1.7: I am informed and able to make choices The people: I know I will be asked for my views. My choices will be respected when making decisions about my wellbeing. If my choices cannot be upheld, I will be provided with information that supports me to understand why. Te Tiriti: High-quality services are provided that are easy to access and navigate. Providers give clear and relevant messages so that individuals and whānau can effectively manage their own health, keep well, and live well. As service providers: We provide people using our services or their legal representatives with the information necessary to make informed decisions in accordance with their rights and their ability to exercise independence, choice, and control.	FA	There was an informed consent policy that was in line with the Code to ensure that a resident who had capacity/competence to consent to treatment or procedure had been given sufficient information to enable them to arrive at reasoned and voluntary decision. Staff interview provided confirmation that additional guidance was provided for staff in the event a resident was unable to provide consent. Competence to provide informed consent was determined by the general practitioner (GP). All resident records sampled had signed consents.

Subsection 1.8: I have the right to complain The people: I feel it is easy to make a complaint. When I complain I am taken seriously and receive a timely response. Te Tiriti: Māori and whānau are at the centre of the health and disability system, as active partners in improving the system and their care and support. As service providers: We have a fair, transparent, and equitable system in place to easily receive and resolve or escalate complaints in a manner that leads to quality improvement.	FA	The organisation had policy and process in place to manage complaints that was in line with Right 10 of the Code of Health and Disability Service Consumers Rights (the Code). The complaint process was made freely available throughout the facility. The facility manager (FM) outlined that should Māori residents require support to navigate the complaints process, support could be accessed through Te Whatu Ora – Taranaki. Residents and whānau stated they were made aware of the complaints process on admission and knew how to access the hard copy form if required. Whānau acknowledged they knew they could also raise issues through the UCG website. There had been three complaints logged over the 2022/2023 period thus far. Interview with the FM and review of the records evidenced that the UCG complaints policy and process had been followed. Information was recorded that evidenced the complainant had been informed of the outcome and was satisfied that it could be closed. There had been no complaints to the Health and Disability Commissioner since the last audit.
Subsection 2.1: Governance The people: I trust the people governing the service to have the knowledge, integrity, and ability to empower the communities they serve. Te Tiriti: Honouring Te Tiriti, Māori participate in governance in partnership, experiencing meaningful inclusion on all governance bodies and having substantive input into organisational operational policies. As service providers: Our governance body is accountable for delivering a highquality service that is responsive, inclusive, and sensitive to the cultural diversity of communities we serve.	FA	The Ultimate Care Rhapsody is part of the UCG which is a registered New Zealand company with the executive team providing direction to the service. There is a governance structure in place which monitors compliance with legislative, contractual, and regulatory requirements. The annual strategic, business plan, had key outcomes which were resident centred, such as resident satisfaction, health and safety, complaints, education, and fiscal stability. These were monitored at board meetings. The national relationships manager (NRM) advised that the core competencies that executive team are required to demonstrate included understanding the organisation's obligations under Te Tiriti o Waitangi, health equity, and cultural safety. Review of resident and whānau survey results evidenced that the organisation valued and prioritised input into service delivery from people receiving care. The UCG executive management team had a clinical governance structure in place that was appropriate to the size and complexity of the organisation. The clinical operations group (COG) reported to the board monthly on key aspects of service delivery.

		The Māori Health Plan described how the organisation would ensure they continued to focus on reducing barriers to equitable service delivery with priorities in place to build trusting relationships, engage residents and whānau in care delivery and continue to develop and strengthen the education programme in relation to cultural safety. The service provides rest home and hospital level care for up to 72 residents. Services were provided across four wings with all rooms as dual purpose. At time of audit there were a total of 56 residents: 47 receiving rest home level care, and 9 receiving hospital level care. Included in these numbers was one hospital level resident on a younger person with disability contract (physical). All other residents were under the aged residential care contract (ARRC) with Te Whatu Ora - Taranaki.
Subsection 2.2: Quality and risk The people: I trust there are systems in place that keep me safe, are responsive, and are focused on improving my experience and outcomes of care. Te Tiriti: Service providers allocate appropriate resources to specifically address continuous quality improvement with a focus on achieving Māori health equity. As service providers: We have effective and organisation-wide governance systems in place relating to continuous quality improvement that take a risk-based approach, and these systems meet the needs of people using the services and our health care and support workers.	FA	The executive team reviewed and approved the quality and risk management plan annually. The plan outlined the identified internal and external risks with risk levels and mitigation strategies included. The plans provide information regarding how the organisation aims to identify potential inequities, reduce disadvantage and promote equality. There was an implemented annual schedule of internal audits. Areas of non-compliance included the implementation of a corrective action plan with sign off by the FM when completed. Identified trends were monitored and raised for discussion within the relevant staff meetings. Recent meeting minutes reviewed evidenced that issues were outlined in the meeting agenda, discussed and documented. This addresses the previous recommendation (criterion 2.2.4). A reporting tool called the manager's reflective report captured a broad range of clinical information across all facilities. The organisation followed the UCG National Adverse Event Reporting policy for internal and external reporting. Section 31 notifications were confirmed as being completed for the appointment of the FM 12 months ago, and the CSM two months ago. Weekly Section 31 notifications are sent to HealthCERT whilst the registered nurse (RN) shortage continued (see 2.3.1) and for wounds/pressure injuries as required.

Subsection 2.3: Service management The people: Skilled, caring health care and support workers listen to me, provide personalised care, and treat me as a whole person. Te Tiriti: The delivery of high-quality health care that is culturally responsive to the needs and aspirations of Māori is achieved through the use of health equity and quality improvement tools. As service providers: We ensure our day-to-day operation is managed to deliver effective person-centred and whānau-centred services.	PA Moderate	Ultimate Care Rhapsody's staffing policy included the rationale for staff rostering and skill mix. This included a facility manager's roster allocation tool to ensure staffing levels were maintained at a safe level. However, at the time of audit there was a significant national health workforce shortage. High staff turnover and a difficulty to recruit registered nurses (RNs) exacerbated the staffing gaps. Interviews with staff, residents, whānau, plus review of the facility roster evidenced that not all shifts were covered by an RN. Level four senior care givers who have completed additional training in health and safety, assessment, and emergency management provided the shift lead role in the absence of an RN. Internationally qualified nurses (IQN) further complemented the roster. The IQNs were completing a competence assessment programme (CAP) to support obtaining their RN qualification in New Zealand. The FM worked 40 hours per week and was available after hours for operational issues. The CSM worked 40 hours per week and was available after hours for clinical support. A part time RN was rostered four nights per week to provide additional clinical support after hours. Laundry staff hours had been increased to reduce the domestic duties workload for care givers and ensure more time was available for resident care. Staffing levels on the morning shift comprised of one RN, or two shift leads (SL) – IQN in the rest home wing, and two SL – IQN in the hospital wing, four care givers in the hospital wing, and two in the rest home wing. The afternoon shift was comprised of two SL – IQN in both the hospital and rest home wings, four care givers in the hospital wing, and one on the rest home wing. The night shift comprises of one SL - IQN and two care givers. Permanent staff picked up additional hours in the case of unplanned staff absence, with a casual team also available to call upon. Review of the current and previous rosters evidenced that each week on average there was 15 shifts without an RN. Staff records sampled evidenced that staff had completed the necessary competencies for their role. There was an implemented annual training programme relevant to the needs of the residents. The clinical administrator (CA) was responsible for recording the ongoing learning and development of staff in tandem with the FM and CSM. The organisation ensured the provision of opportunities for ongoing development for health care and support workers. Staff confirmed they were supported to upskill and maintain competency and felt valued as employees. One RN had

		completed InterRAI training with two others booked for training. The organisation had implemented systems that ensured the accurate collection and sharing of Māori health information. The UCG cultural safety policy outlined that on admission each resident's ethnicity and specific cultural beliefs/values shall be documented in their individual care plan. Care plans sampled evidenced this was completed. The previous identified area for improvement (criterion 2.3.1) is partially closed with part ii) relating to domestic duties on the afternoon and night shift being closed. However, part i) service provider availability remains open.
Subsection 2.4: Health care and support workers The people: People providing my support have knowledge, skills, values, and attitudes that align with my needs. A diverse mix of people in adequate numbers meet my needs. Te Tiriti: Service providers actively recruit and retain a Māori health workforce and invest in building and maintaining their capacity and capability to deliver health care that meets the needs of Māori. As service providers: We have sufficient health care and support workers who are skilled and qualified to provide clinically and culturally safe, respectful, quality care and services.	FA	Human resource management practices followed policies and processes which adhered to the principles of good employment practice and the Employment Relations Act 2000. Review of staff records confirmed the organisation's policy was consistently implemented and records were maintained. Recruitment processes included police vetting, and reference checks with the FM taking responsibility for validating prospective staff members qualifications as well as the annual checks required. The UCG orientation policy outlined that all new staff were to complete an orientation which included information specific to the organisation and facility. Additional learning requirements were set out for each designation. New staff were buddied with an experienced staff member for a designated time which could be extended if required. Staff stated they had received orientation that was appropriate to their role with a review of staff records providing evidence this was completed. Records sampled and discussion with the FM confirmed that information held about staff was accurate, relevant, and kept in a secure location with confidentiality maintained. There was an implemented system that ensured all staff had an opportunity to discuss and review their performance at defined intervals. Records evidenced that performance reviews were current and clinical staff reviews had input from a senior clinical staff member. The previous identified area for improvement (criterion 2.4.5) relating to performance appraisals is now closed.

Subsection 3.2: My pathway to wellbeing The people: I work together with my service providers so they know what matters to me, and we can decide what best supports my wellbeing. Te Tiriti: Service providers work in partnership with Māori and whānau, and support their aspirations, mana motuhake, and whānau rangatiratanga. As service providers: We work in partnership with people and whānau to support wellbeing.	PA Moderate	Resident care plans were developed using an electronic system. Registered nurses were responsible for all residents' assessments, care planning and evaluation of care. Initial care plans were developed with the residents/next of kin/whānau or EPOA consent. They were based on data collected during the initial nursing assessments and on information from pre-entry assessments completed by the needs assessment service co-ordination (NASC) or other referral agencies. The assessments included information about, but not limited to, the resident's medical history, pain, nutrition, mobility, and skin condition. Assessments reviewed had been completed in consultation with the resident and whānau. Residents interviewed confirmed assessments were completed according to their needs and in the privacy of their bedrooms. The residents' cultural, spiritual and activities assessments were completed by the diversional therapist (DT). Information on residents' cultural needs, previous life experiences, interests, whānau, and spiritual needs is gathered during interview with the resident and/or their whānau and documented. Assessments were used to develop the resident's individual pastoral and activity care plans. The residents' activity needs are reviewed six monthly. The individualised long term care plans (LTCPs) were developed with information gathered during the initial assessments and from the interRAI assessment. Documented interventions and early warning signs addressed the residents' assessed needs. The previous recommendations relating to criterion cultural assessments, documentation of interventions and care plan information have been implemented however, the timeliness of the interRAI assessment and the development of the LTCP requires improvement. Short term care plans are developed for acute problems, for example, infections. A Māori health care plan was used for residents identifying as Māori. The care plan guided staff in gathering information and documenting the support required to meet the Māori resident's needs. The initial medical assessment was completed by the GP following admission. Residents' reviews by the GP were completed within required timeframes and when their health status changed. There was documented evidence of the exemption from monthly GP visits when the resident's

		condition was considered stable. The GP interviewed visited the facility weekly and as required. They provided an after-hours service. A physiotherapist visited regularly and saw residents referred by the CSM or RNs. Staff interviewed and education records sighted confirmed that staff had completed cultural training. Staff interviewed discussed how they implemented the learnings of tikanga Māori into their practice and provided examples. Resident and whānau interviews and records confirmed that they were kept informed of any changes, for example, GP visits, changes in medication and incidents. Provision of care reflected in the care plan was consistent with, and contributed to, meeting the residents assessed needs, goals, and aspirations. Support was identified for whānau. Staff discussed service provision to include providing services free from stigma and those which promoted acceptance and inclusion. Nursing progress notes were maintained. Monthly observations such as weight and blood pressure were completed and were up to date. Neurological observations are recorded following all unwitnessed falls. The previous area identified as requiring improvement regarding neurological observations, relating to criterion 1.6.3 is now closed. Policies and procedures were in place to ensure continuity of service delivery. Staff interviews confirmed they were familiar with the needs of all residents and that they had access to the supplies and products they required. There was evidence of wound care products available. Review of wound care plans evidenced wounds were assessed in a timely manner and reviewed at appropriate intervals. Photos and measurements are taken as required. Where wounds required additional specialist input, this was initiated. Resident care was evaluated on each shift and reported at handover and in the progress notes. If any change was noted, this was reported to the RN, however six-monthly evaluations of the long-term care plans and evaluation when there is a change in a resident's condition requires improvement. The previous area identified as requiring improvement relating to evaluation for change in condition remains open (3.2.5). Short term care plans were reviewed regularly and signed off when the problem is resolved. Handover meetings between each shift ensure

		residents progress towards meeting identified goals are discussed. Ultimate Care Group has developed policies and procedures in conjunction with the other relevant services and organisations to support tāngata whaikaha. These services and organisations had representation from tāngata whaikaha.
Subsection 3.4: My medication The people: I receive my medication and blood products in a safe and timely manner. Te Tiriti: Service providers shall support and advocate for Māori to access appropriate medication and blood products. As service providers: We ensure people receive their medication and blood products in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Moderate	A current medication management policy identified all aspects of medicine management in line with relevant legislation, standards and guidelines. A safe system for medicine management using an electronic system was observed on the day of audit. The provider used pharmacy pre-packaged medicines that were checked by an RN on delivery. A system is in place for returning expired or unwanted medication. Stock medication is available only for hospital level residents. Stock medications sighted were within current use by dates, however monitoring of the medication refrigerator temperature and medication room temperature requires improvement. Controlled medications were stored securely in accordance with requirements. Controlled medications were checked by two staff for accuracy in administration. The required six monthly stocktake was completed however weekly checks of medications requires improvement. Resident allergies and sensitivities were documented on the electronic medication chart and in the resident's electronic record. Staff were observed administering medication at interview demonstrated clear understanding of their roles and responsibilities related to each stage of medication management and complied with the medicine administration policies and procedures. Registered nurses oversee the use of all ‘as required’ (PRN) medicines and documentation made regarding effectiveness was sighted. Current medication competencies were evident in staff files. Policies and procedures are in place relating to self-administration of medication. No residents were self-administering medication. There were no standing orders in place.

Subsection 3.5: Nutrition to support wellbeing The people: Service providers meet my nutritional needs and consider my food preferences. Te Tiriti: Menu development respects and supports cultural beliefs, values, and protocols around food and access to traditional foods. As service providers: We ensure people's nutrition and hydration needs are met to promote and maintain their health and wellbeing.	FA	A nutritional assessment was undertaken by a RN for each resident on admission to identify the residents' dietary requirements, allergies/sensitivities, and preferences. The nutritional profiles were communicated to the kitchen staff and updated when a resident's dietary needs changed. Diets were modified as needed and the cook confirmed awareness of the dietary needs, allergies/sensitivities, likes and dislikes and dietary cultural needs of residents. These were accommodated in daily meal planning. The food service was provided in line with recognised nutritional guidelines for older people. The seasonal menu had been approved by a New Zealand registered dietician, with the winter menu implemented at the time of audit. The Food Control Plan expiry date is April 2024.
Subsection 3.6: Transition, transfer, and discharge The people: I work together with my service provider so they know what matters to me, and we can decide what best supports my wellbeing when I leave the service. Te Tiriti: Service providers advocate for Māori to ensure they and whānau receive the necessary support during their transition, transfer, and discharge. As service providers: We ensure the people using our service experience consistency and continuity when leaving our services. We work alongside each person and whānau to provide and coordinate a supported transition of care or support.	FA	Records sampled reviewed evidenced that transition, exit, discharge, or transfer was managed with consultation with residents and whānau in a planned and coordinated manner and included information on current needs. The transfer/discharge documentation was generated by the electronic system and included, but was not limited to, risk management information, a summary care plan and medication chart.
Subsection 4.1: The facility The people: I feel the environment is designed in a way that is safe and is sensitive to my needs. I am able to enter, exit, and move around the environment freely and safely. Te Tiriti: The environment and setting are designed to be Māori-centred and culturally safe for Māori and whānau.	FA	A building warrant of fitness was current to February 2024. Buildings, plant, and equipment complied with legislation relevant to the health and disability service provided. Staff provided evidence that the calibration of equipment and electrical testing and tagging was completed, and the preventative and reactive maintenance schedule was maintained. The internal and external physical environment was noted to be safe and accessible and promoted

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.		safe mobility and independence. Areas were available throughout the facility that enabled residents to meet privately with visitors and partake in cultural activities if they wished.
Subsection 5.2: The infection prevention programme and implementation The people: I trust my provider is committed to implementing policies, systems, and processes to manage my risk of infection. Te Tiriti: The infection prevention programme is culturally safe. Communication about the programme is easy to access and navigate and messages are clear and relevant. As service providers: We develop and implement an infection prevention programme that is appropriate to the needs, size, and scope of our services.	FA	The infection control programme was appropriate for the size and complexity of the service. The infection prevention and control programme was reviewed annually and linked to the quality and business plan. The UCG clinical operations group (COG) involved staff at site level in the review of policies and procedures and the infection prevention and control nurse (IPCN) had input when IP policies and procedures were reviewed. The IPCN reports to the regional manager and the clinical coach. Audit outcomes are benchmarked against other UCG facilities, and this information is available to the facility staff and to the board. An RN was the infection prevention and control nurse (IPCN) and had completed training for the role. The CSM and IPCN were responsible for coordinating/providing education and training to staff. The orientation package included specific training around hand hygiene and standard precautions. Annual infection control training was included in the mandatory in-services. Staff had completed infection control education in the last 12 months. The IPCN had access to an online training system with resources, guidelines, and best practice.
Subsection 5.4: Surveillance of health care-associated infection (HAI) The people: My health and progress are monitored as part of the surveillance programme. Te Tiriti: Surveillance is culturally safe and monitored by ethnicity. As service providers: We carry out surveillance of HAIs and multi-drug-resistant organisms in accordance with national and regional surveillance programmes, agreed objectives,	PA Low	Surveillance was an integral part of the infection control programme. The surveillance undertaken was detailed in the infection prevention and control programme. This included monitoring positive results for infections and outbreaks. The purpose and methodology were described in the UCG surveillance policy. The CSM and the ICPN used the information obtained through surveillance to determine infection control activities, resources and education needs within the service. Monthly infection data was collected for all infections based on standard definitions, however not all required detail was included in the data

priorities, and methods specified in the infection prevention programme, and with an equity focus.		collection or reporting. Infection control data was monitored and evaluated monthly and annually. Trends were identified and analysed, and corrective actions were established where trends were identified. These, along with outcomes and actions were discussed at the staff meetings. Meeting minutes were available to all staff. Variances in trends in surveillance data were identified and investigated as verified during interview. Staff were made aware of new infections at handovers on each shift, progress notes and clinical records. Short term care plans were developed to guide care for residents with an infection. There were processes in place to isolate infectious residents when required. Monthly surveillance data was collected and reported to the executive team. Trends, and opportunities to improve were considered by the CSM, the IPCN and the national clinical services manager. There were no trends identified in IPC documents sampled.
Subsection 6.1: A process of restraint The people: I trust the service provider is committed to improving policies, systems, and processes to ensure I am free from restrictions. Te Tiriti: Service providers work in partnership with Māori to ensure services are mana enhancing and use least restrictive practices. As service providers: We demonstrate the rationale for the use of restraint in the context of aiming for elimination.	FA	The provider promoted a restraint free environment. All restraint practice was managed through an established process consistently across all Ultimate Care Group facilities. Executive leaders received restraint reports monthly alongside aggregated restraint data, including the type and frequency of restraint if restraint had occurred. This formed part of regular reporting to the board. Records confirmed the completion of restraint minimisation and safe restraint use training with annual updates completed. Staff reported they were trained and considered competent to manage challenging behaviour. Staff records, documentation confirmed this. Staff interviewed, confirmed the processes that were required for Māori residents when considering restraint or if restraint practice was implemented. There were no residents using restraint during the audit.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 2.3.1 Service providers shall ensure there are sufficient health care and support workers on duty at all times to provide culturally and clinically safe services.	PA Moderate	Due to the effects of the national pandemic, global health workforce shortages, and staff turnover, the provider does not meet the requirements of the aged residential care (ARRC) agreement with Te Whatu Ora – Taranaki for 24/7 RN cover. Risk mitigation in place included, the FM, CSM, and an RN providing after-hours operational and clinical support, more complex residents had been declined until the RN staffing levels increased, laundry staff had been rostered additional hours to free up care staff to provide more dedicated time to resident care, and a recruitment process were underway for additional RN resource.	The provider was unable to provide RN cover 24 hours a day, seven days per week as per contractual obligations.	Ensure there is sufficient RN cover as per contractual obligations. 180 days
Criterion 3.2.3 Fundamental to the development	PA Moderate	Short term care plans were in place for acute problems however not all residents	A long-term care plan is not developed for all residents	Ensure that all residents have an interRAI

of a care or support plan shall be that: (a) Informed choice is an underpinning principle; (b) A suitably qualified, skilled, and experienced health care or support worker undertakes the development of the care or support plan; (c) Comprehensive assessment includes consideration of people's lived experience; (d) Cultural needs, values, and beliefs are considered; (e) Cultural assessments are completed by culturally competent workers and are accessible in all settings and circumstances. This includes traditional healing practitioners as well as rākau rongoā, mirimiri, and karakia; (f) Strengths, goals, and aspirations are described and align with people's values and beliefs. The support required to achieve these is clearly documented and communicated; (g) Early warning signs and risks that may adversely affect a person's wellbeing are recorded, with a focus on prevention or escalation for appropriate intervention; (h) People's care or support plan identifies wider service integration as required.		had a long-term care plan in place. Initially five resident records were reviewed, however the sample was extended following review of wound care plans as during this review it became evident that not all residents had a long-term care plan in place. The original sample of five was extended to nine. Three out of nine files reviewed evidenced had no long-term care plan in place, these residents had been admitted in April, May and June 2023. One other resident had a LTCP in place, but this had been developed three months after they were admitted. Residents were assessed by an RN on admission however not all residents had an interRAI assessment within the required timeframe following admission. In four out of nine resident records reviewed the InterRAI assessment had not been completed within the required three-week period, for two of these the interRAI was completed eight weeks following admission.	within three weeks of admission. The completion of the InterRAI assessment within three weeks of admission is inconsistent.	assessment and long-term care plan developed in the required timeframe following admission. 90 days

Criterion 3.2.5 Planned review of a person's care or support plan shall: (a) Be undertaken at defined intervals in collaboration with the person and whānau, together with wider service providers; (b) Include the use of a range of outcome measurements; (c) Record the degree of achievement against the person's agreed goals and aspiration as well as whānau goals and aspirations; (d) Identify changes to the person's care or support plan, which are agreed collaboratively through the ongoing re-assessment and review process, and ensure changes are implemented; (e) Ensure that, where progress is different from expected, the service provider in collaboration with the person receiving services and whānau responds by initiating changes to the care or support plan.	PA Moderate	Resident care was evaluated on each shift and reported at handover and in the progress notes. If any change was noted, this was reported to the RN, however long-term care plan evaluations did not consistently occur six monthly or when there was a change in the resident's condition. In the initial sample of five files, two had not been evaluated six monthly as required and one had not been evaluated and updated for a change in condition.	Long term care plans were not consistently evaluated every six months or when there was a change in the resident's condition.	Ensure that long term care plans are evaluated at least every six months and / or when there is a change in the resident's condition. 90 days
Criterion 3.4.3 Service providers ensure competent health care and support workers manage medication including: receiving, storage, administration,	PA Moderate	Stock medications sighted were within current use by dates however, monitoring of the medication refrigerator temperatures and medication room temperatures requires improvement. The temperatures were not recorded on several occasions in the past	Medication room and medication fridge temperatures are not recorded consistently as per UCG policy. Controlled medications were not checked weekly as per	Ensure that medication fridge and medication room temperatures are monitored as per UCG policy and that a check of the controlled medications

monitoring, safe disposal, or returning to pharmacy.		month. The required six monthly stocktake was completed however weekly checks of medications are not conducted in line with policy and legislation. There was evidence of occasional checks of the controlled medications, but this was not done every week as required.	UCG policy.	is carried out weekly. 30 days
Criterion 5.4.3 Surveillance methods, tools, documentation, analysis, and assignment of responsibilities shall be described and documented using standardised surveillance definitions. Surveillance includes ethnicity data.	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 did not include the resident's ethnicity.	Ensure surveillance reports include the resident's ethnicity. 180 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.