

The Ultimate Care Group Limited - Ultimate Care Poneke House

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 Manatū Hauora (the Ministry of Health).

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

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

The specifics of this audit included:

Legal entity: The Ultimate Care Group Limited

Premises audited: Ultimate Care Poneke House

Services audited: Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care

Dates of audit: Start date: 14 November 2023 End date: 15 November 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: 44

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All subsections applicable to this service are fully attained with some subsections exceeded
	No short falls	Subsections applicable to this service are 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 are partially attained and of low risk

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

General overview of the audit

Ultimate Care Poneke is part of Ultimate Care Group Limited. It is certified to provide services for up to 50 residents requiring rest home, hospital (geriatric and medical), or (secure) dementia level care. On day of audit 44 beds were occupied. The facility was managed by a facility manager, and a clinical services manager. Both of whom had been appointed since the last audit. The facility manager had been in the role for six months. The clinical services manager has been in the role for one month and was completing the organisational and facility orientation. There had been no other changes to the organisation or within the facility.

This unannounced surveillance audit was conducted against the Ngā Paerewa Health and Disability Services Standard NZS8134:2021 and the organisation's agreement with Te Whatu Ora – Capital, Coast and Hutt Valley.

The audit process included review of policies and procedures, review of resident and staff records, observations, and interviews with residents, whānau, management, staff and a nurse practitioner.

One previously identified area requiring improvement, relating to the provision of registered nurse cover remains open. There were no other areas identified as requiring improvement from the last certification audit.

Areas identified at this audit as requiring improvement relate to complaint management, human resource management, environment, communication/documentation, and care planning.

Ō tātou motika | Our rights

Includes 10 subsections that support an outcome where people receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of people's rights, facilitates informed choice, minimises harm, and upholds cultural and individual values and beliefs.		Some subsections applicable to this service are partially attained and of low risk.
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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. Residents received services in a manner that was responsive to and respected their individuality and upheld their right to dignity, privacy and independence. The provider had a culture of open disclosure.

Care plans accommodated the choices of resident's and their whānau.

Hunga mahi me te hanganga | Workforce and structure

Includes five subsections that support an outcome where people receive quality services through effective governance and a supported workforce.		Some subsections applicable to this service are partially attained and of medium or high risk and/or unattained and of low risk.
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Ultimate Care Group Limited is the governing body responsible for the services provided. The provider had current business, 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.

The newly appointed clinical services manager was receiving orientation to lead the clinical and care services. The Ultimate Care Group clinical coach is providing additional support. 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 eight subsections that support an outcome where people participate in the development of their pathway to wellbeing, and receive timely assessment, followed by services that are planned, coordinated, and delivered in a manner that is tailored to their needs.		Some subsections applicable to this service are partially attained and of low risk.
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Registered nurses assessed residents on admission with input from the resident and/or whānau. The initial care plan guided care and service provision during the first three weeks after the resident's admission.

InterRAI assessments were used to identify residents' needs. Long term care plans were developed and implemented within the required timeframes. The nurse 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. All meals were 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 two subsections that support an outcome where Health and disability services are provided in a safe environment appropriate to the age and needs of the people receiving services that facilitates independence and meets the needs of people with disabilities.		Some subsections applicable to this service are partially attained and of low risk.
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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 participate in cultural activities.

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

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

Subsections applicable to this service are fully attained.

The clinical services manager led the infection control programme. Organisational COVID-19 prevention strategies were in place including a pandemic plan. Infection data was collated, analysed, trended, and reported to staff and the board.

Here taratahi | Restraint and seclusion

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

Subsections applicable to this service are fully attained.

Restraint minimisation and safe practice policies and procedures were in place. Restraint was overseen by the Ultimate Care Group Limited 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	13	0	4	1	0	0
Criteria	0	40	0	9	1	0	0

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

Attainment against the Ngā paerewa Health and disability services standard

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

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

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

Subsection with desired outcome	Attainment Rating	Audit Evidence
<p>Subsection 1.1: Pae ora healthy futures</p> <p>Te Tiriti: Māori flourish and thrive in an environment that enables good health and wellbeing. As service providers: We work collaboratively to embrace, support, and encourage a Māori worldview of health and provide high-quality, equitable, and effective services for Māori framed by Te Tiriti o Waitangi.</p>	FA	<p>Staff 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 were embedded in care delivery. Current staff had completed training except staff who were completing orientation.</p> <p>The organisation had a Māori health action plan that recognised the principles of Te Tiriti o Waitangi and 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.</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. Te Tiriti: Pacific peoples acknowledge the mana whenua of Aotearoa as tuakana and commit to supporting them to</p>	FA	<p>The Pacific plan outlined the organisation’s commitment to providing culturally safe care and defined and explained 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. Staff interviews provided examples of what was</p>

<p>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.</p>		<p>provided for residents who identify as Pacific to address their cultural and spiritual beliefs. There were residents who identified as Pacific residing in the facility at time of audit.</p>
<p>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.</p>	<p>FA</p>	<p>The Code of Health and Disability Services Consumer's 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 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 with opportunities to discuss their rights.</p>
<p>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.</p>	<p>FA</p>	<p>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, resident, and whānau interviews evidenced that there was no evidence of abuse or neglect. Staff described professional boundaries and how these were maintained.</p> <p>The admission agreement signed prior to occupation provided clear expectations regarding the 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.</p> <p>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.</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>	FA	<p>There was an informed consent policy that was in line with the Code to ensure that a resident who had the capacity/competence to consent to treatment or a procedure had been given sufficient information to enable them to arrive at a reasoned and voluntary decision. Staff interview provided confirmation that additional guidance was provided 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 evidenced that residents had signed consents for photographs, outings and the collection and sharing of information.</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.</p> <p>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>	PA Low	<p>The organisation had policy and process in place to manage complaints that was in line with Right 10 of the Code. The complaint process was made available in the admission agreement and explained by staff as part of the admission process. Complaint forms were freely available throughout the facility. Resident and whānau interviews evidenced that the complaint process was explained on admission, and that they knew how to access the hard copy form if required. Whānau also acknowledged they were aware they could raise issues through the UCG website. Interview with staff evidenced that the provider has established links with a local Marae and support can be provided for Māori residents if required to navigate the complaints process.</p> <p>The facility manager (FM) took responsibility for managing complaints. There had been four complaints over the 2022/2023 period thus far. Interview with the FM and review of documentation evidenced that the UCG complaints policy and process was not fully implemented. The FM advised that there had been no known complaints to/from the Health and Disability Commissioner (HDC) or other external agencies since the last audit.</p>

<p>Subsection 2.1: Governance</p> <p>The people: I trust the people governing the service to have the knowledge, integrity, and ability to empower the communities they serve.</p> <p>Te Tiriti: Honouring Te Tiriti, Māori participate in governance in partnership, experiencing meaningful inclusion on all governance bodies and having substantive input into organisational operational policies.</p> <p>As service providers: Our governance body is accountable for delivering a highquality service that is responsive, inclusive, and sensitive to the cultural diversity of communities we serve.</p>	<p>FA</p>	<p>Ultimate Care Poneke is part of the UCG which is a registered New Zealand company with the executive team providing direction to the service. There is governance structure in place that monitors compliance with legislative, contractual, and regulatory requirements.</p> <p>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) has explained that the core competencies that executive team are required to demonstrate include 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.</p> <p>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 reported to the board monthly on key aspects of service delivery.</p> <p>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.</p> <p>The provider is certified to provide care for up to 50 residents requiring hospital (geriatric and medical), rest home, and dementia level care. Services are provided over two floors with the dementia area on the ground floor accessible via a lift or an internal stair well. At time of audit there were 44 residents. This included 18 residents receiving rest home level care, 11 residents receiving hospital level care, and 15 residents receiving dementia level care. This was inclusive of one young person under 65 years of age with a physical disability receiving hospital level services.</p>
<p>Subsection 2.2: Quality and risk</p>	<p>FA</p>	<p>The executive team reviewed and approved the quality and risk management plan annually. The plan outlined the identified internal and</p>

<p>The people: I trust there are systems in place that keep me safe, are responsive, and are focused on improving my experience and outcomes of care.</p> <p>Te Tiriti: Service providers allocate appropriate resources to specifically address continuous quality improvement with a focus on achieving Māori health equity.</p> <p>As service providers: We have effective and organisation-wide governance systems in place relating to continuous quality improvement that take a risk-based approach, and these systems meet the needs of people using the services and our health care and support workers.</p>		<p>external organisational risks with mitigation strategies included. The plan provide information regarding how the organisation aims to identify potential inequities and reduce disadvantage.</p> <p>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 quality/staff meetings. A manager's reporting tool captured a broad range of clinical information for benchmarking purposes across all facilities.</p> <p>The organisation followed the UCG Adverse Event Reporting policy for internal and external reporting. Section 31 notifications were sent to HealthCERT weekly whilst the current registered nurse shortage continues (see 2.3.1), and for wounds/pressure injuries as required. Section 31 notifications were confirmed as being completed for the appointment of the FM six months ago and the clinical services manager (CSM) one month ago.</p>
<p>Subsection 2.3: Service management</p> <p>The people: Skilled, caring health care and support workers listen to me, provide personalised care, and treat me as a whole person.</p> <p>Te Tiriti: The delivery of high-quality health care that is culturally responsive to the needs and aspirations of Māori is achieved through the use of health equity and quality improvement tools.</p> <p>As service providers: We ensure our day-to-day operation is managed to deliver effective person-centred and whānau-centred services.</p>	<p>PA Moderate</p>	<p>Ultimate Care Poneke staffing policy included the rationale for staff rostering and skill mix. This included a facility managers' roster allocation tool to ensure staffing levels were maintained at a safe level. However, at time of audit there was a national health workforce shortage. High staff turnover and difficulty to recruit new registered nurses (RNs) exacerbated the staffing gaps. Interviews with staff, residents and whānau, plus review of the rosters 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 provide the shift lead role in the absence of an RN.</p> <p>The FM worked 40 hours per week and was available after hours for operational issues. Whilst the CSM was completing orientation and the provider continued to have a RN shortage, the UCG executive team was providing senior clinical support after hours. Laundry and cleaning staff were rostered part time hours across the week. Staffing levels on the morning shift comprised of one RN or shift lead, four care givers for the hospital and rest home wings, and two care givers for the dementia wing. The afternoon shift comprised of one RN or shift lead, three care givers</p>

		<p>across the hospital and rest home wings, and two care givers in the dementia wing. The night shift comprised of one shift lead and two care givers across the facility. Care givers working short shifts complement the shifts in accordance with acuity. Review of current and previous rosters evidenced that each week on average there was seven shifts without an RN.</p> <p>Staff records sampled evidenced that staff completed competencies for their role. There was an implemented programme relevant to the needs of the residents. The FM and administrator worked in tandem to record the ongoing learning and development of staff. Staff confirmed they were supported to upskill and maintain competency. Two RNs had completed InterRAI training with one booked to complete this shortly.</p> <p>The previous identified area for improvement relating to RN availability remains open.</p>
<p>Subsection 2.4: Health care and support workers</p> <p>The people: People providing my support have knowledge, skills, values, and attitudes that align with my needs. A diverse mix of people in adequate numbers meet my needs.</p> <p>Te Tiriti: Service providers actively recruit and retain a Māori health workforce and invest in building and maintaining their capacity and capability to deliver health care that meets the needs of Māori.</p> <p>As service providers: We have sufficient health care and support workers who are skilled and qualified to provide clinically and culturally safe, respectful, quality care and services.</p>	<p>PA Low</p>	<p>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 that recruitment processes included police vetting and reference checking. Required qualifications and annual practising certificates checks were conducted on commencement of employment for those staff that required these however there is improvement required to ensure staff maintain currency.</p> <p>The UCG orientation policy outlined that all new staff are to receive an orientation which includes information specific to the organisation and the facility. Additional learning requirements were set out for each designation that was appropriate to their role. New staff were buddied with an experienced staff member for a designated time which can be extended if required. Staff interviewed stated they had received an orientation. However, improvement is required regarding documentation of the process.</p> <p>The organisation had a performance review process in place however improvement is required to ensure all staff receive a review at defined intervals.</p> <p>Staff employment information was kept in a secure location and</p>

		confidentiality was maintained.
<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>	PA Low	<p>RNs were responsible for all residents' assessments, care planning and evaluation of care. Resident care plans were developed using an electronic system. Initial care plans were developed with the residents/EPOA consent within the required timeframe. They were based on data collected during the initial nursing assessments, which includes dietary needs; pressure injury risk; falls risk, social history and information from pre-entry assessments completed by the Needs Assessment and Service Co-ordination (NASC) or other referral agencies.</p> <p>The individualised long term care plans (LTCPs) were developed with information gathered during the initial assessment and the interRAI assessment and completed within three weeks of the residents' admission. Documented interventions and early warning signs met the residents' assessed needs, however the development of short-term care plans (STCPs) for acute problems requires improvement.</p> <p>Review of residents' records showed that the resident under the young person with a disability contract participated in care planning. Their plan included activities and interventions to ensure that their physical health, mental health, cultural and wellbeing needs were met. The residents who identified as Māori had a Māori health care plan in place which described the support required.</p> <p>The residents' activities assessments were completed by the diversional therapist (DT) within in three weeks of the residents' admission. Information on residents' interests, family/whānau, and previous occupation was gathered during interview with the resident and/or their family/whānau and documented. The activity assessments included a cultural assessment which gathers information about cultural needs, values, and beliefs. Information from these assessments was used to develop the resident's individual activity care plan. The residents' activity needs were reviewed six monthly at the same time as the care plans.</p> <p>The initial medical assessment was undertaken by the nurse practitioner (NP) or general practitioner (GP) within the required timeframe following admission. Residents had reviews by the NP or GP within required timeframes and when their health status changed. There was documented</p>

		<p>evidence of the exemption from monthly GP/NP visits when the resident's condition was considered stable. The NP visits the facility weekly and provides an after-hours service. Documentation and records reviewed were current. The NP interviewed commented positively about communication with the service, the care of the residents and that they were informed of concerns in a timely manner.</p> <p>Contact details for family/whānau were recorded on the electronic system. Family/whānau/EPOA interviews and resident records evidenced that family/whānau were involved and consulted at each routine medical review and case conference, however, documentation for family/whānau contact in the event of a change in condition, change of medication or an adverse event requires improvement.</p> <p>There was evidence of wound care products available. Review of the wound care plans evidenced wounds were assessed in a timely manner and reviewed at appropriate intervals. Photos and measurements were recorded where this was required. Where wounds required additional specialist input, this was initiated.</p> <p>Policies and protocols 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. Staff received a verbal handover at the beginning of their shift.</p> <p>Monthly observations such as weight and blood pressure were completed and were up to date, however interventions to address any issues identified requires improvement. Neurological observations were recorded following all unwitnessed falls.</p> <p>Resident care was evaluated on each shift and reported at handover and in the progress notes. If any change is noted, it is reported to the RN. InterRAI re-assessments were completed six monthly and when there was a change in the resident's condition, however six-monthly evaluations of the LTCPs and review of STCPs requires improvement.</p> <p>Residents interviewed confirmed assessments were completed according to their needs and in the privacy of their bedrooms.</p>
<p>Subsection 3.4: My medication The people: I receive my medication and blood products in a</p>	<p>FA</p>	<p>A current medication management policy identified all aspects of medicine management in line with relevant legislation, standards and guidelines. This</p>

<p>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.</p>		<p>includes a policy for self-administration of medication. A safe system for medicine management using an electronic system was observed on the day of audit. Prescribing practices are in line with legislation, protocols, and guidelines. The required three-monthly reviews by the GP are recorded electronically. Resident allergies and sensitivities are documented on the electronic medication chart and in the resident's electronic record.</p> <p>The provider used pharmacy pre-packaged medicines that were checked by an RN on delivery. Stock medication was available only for hospital level residents. Stock medications sighted were within current use by dates. A system was in place for returning expired or unwanted medication. The medication refrigerator and medication room temperatures were monitored as per UCG policy and were within the required range.</p> <p>Resident allergies and sensitivities were documented on the electronic medication chart and in the resident's electronic record.</p> <p>Controlled medications were stored securely in accordance with requirements. Controlled medications were checked by two staff for accuracy in administration. Weekly checks of medications and six monthly stocktakes were conducted in line with policy and legislation.</p> <p>Staff observed administering medication 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.</p> <p>No residents were self-administering medication. There were no standing orders in place.</p>
<p>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</p>	<p>FA</p>	<p>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 kitchen staff and updated when a resident's dietary needs change. Diets were modified as needed and the cook confirmed awareness of the dietary needs, allergies/ sensitivities, likes and dislikes and dietary cultural needs of residents. These were accommodated in daily meal planning. Discussion</p>

<p>hydration needs are met to promote and maintain their health and wellbeing.</p>		<p>on the menu takes place on an individual basis by the cook and is an agenda item at all resident's meetings.</p> <p>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. The Food Control Plan expiry date was May 2025.</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>Records sampled 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 includes, but was not limited to, risk management information, a summary care plan, resuscitation status and medication chart. The provider uses the 'yellow envelope' system for transfers to another service or facility.</p>
<p>Subsection 4.1: The facility</p> <p>The people: I feel the environment is designed in a way that is safe and is sensitive to my needs. I am able to enter, exit, and move around the environment freely and safely.</p> <p>Te Tiriti: The environment and setting are designed to be Māori-centred and culturally safe for Māori and whānau.</p> <p>As service providers: Our physical environment is safe, well maintained, tidy, and comfortable and accessible, and the people we deliver services to can move independently and freely throughout. The physical environment optimises people's sense of belonging, independence, interaction, and function.</p>	<p>PA Low</p>	<p>A building warrant of fitness was current to June 2024. Buildings, plant and equipment complied with legislation relevant to the health and disability service provided.</p> <p>Staff provided evidence that the calibration of equipment and electrical testing and tagging was completed, and that a preventative and reactive maintenance schedule was maintained.</p> <p>The external area was noted to be safe and accessible. The outdoor area designated for the residents assessed as requiring dementia level care was secure and provided shaded areas to sit and to walk around safely and enjoy the garden. The internal area provided private nooks for residents to meet with their visitors and partake in cultural activities if they wished. The sensory room in the dementia wing was noted to have a hole in the floor with jagged edges posing a hazard for residents in that area.</p>

<p>Subsection 5.2: The infection prevention programme and implementation</p> <p>The people: I trust my provider is committed to implementing policies, systems, and processes to manage my risk of infection.</p> <p>Te Tiriti: The infection prevention programme is culturally safe. Communication about the programme is easy to access and navigate and messages are clear and relevant.</p> <p>As service providers: We develop and implement an infection prevention programme that is appropriate to the needs, size, and scope of our services.</p>	<p>FA</p>	<p>The infection control programme was appropriate for the size and complexity of the service. The infection prevention 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 were benchmarked against other UCG facilities, and this information was available to the facility, staff and the board.</p> <p>The newly appointed CSM was the infection prevention nurse (IPN), and training has been planned for them to meet the requirements for their role. The IPN will be 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-service programme. Staff had completed infection control education in the last 12 months. The IPN had access to an online training system with resources, guidelines, and best practice.</p>
<p>Subsection 5.4: Surveillance of health care-associated infection (HAI)</p> <p>The people: My health and progress are monitored as part of the surveillance programme.</p> <p>Te Tiriti: Surveillance is culturally safe and monitored by ethnicity.</p> <p>As service providers: We carry out surveillance of HAIs and multi-drug-resistant organisms in accordance with national and regional surveillance programmes, agreed objectives, priorities, and methods specified in the infection prevention programme, and with an equity focus.</p>	<p>FA</p>	<p>Surveillance was an integral part of the infection prevention 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 IPCN used the information obtained through surveillance to determine infection control activities, resources and education needs within the service.</p> <p>Monthly infection data was collected for all infections based on standard definitions. Surveillance included ethnicity data. Infection prevention 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 staff meetings. Meeting minutes were available to all staff. Variances in trends of surveillance data were identified and investigated as verified during interview.</p> <p>Staff were made aware of new infections at handovers on each shift, and</p>

		<p>within progress notes/clinical records. Short term care plans were developed to guide care for residents with an infection, however these require improvement (refer finding 3.2.5). There were processes in place to isolate infectious residents when required. There have been no outbreaks since the previous audit.</p>
<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>	<p>FA</p>	<p>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.</p> <p>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 sampled confirmed this. Staff interviewed, confirmed the processes that were required for Māori residents when considering restraint or if restraint practice was implemented.</p> <p>There were no residents using restraint during the audit.</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 1.8.3</p> <p>My complaint shall be addressed and resolved in accordance with the Code of Health and Disability Services Consumers' Rights.</p>	PA Low	<p>Review of the complaints register and interview with the FM evidenced that complaints were not consistently managed in accordance with UCG policy and procedure. Not all complaints were recorded on the complaints register, not all documentation pertinent to the complaint was filed with the complaint, and evidence was missing that outlined that the complaint had been fully investigated and was able to be closed.</p>	<p>The UCG complaints policy and process was not fully implemented and maintained.</p>	<p>Ensure all complaints are managed in accordance with UCG 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	<p>Review of the complaints register and discussion with the FM evidenced that not all complainants were informed of the outcome of their complaint.</p>	<p>The UCG complaint management process was inconsistently followed and not all complainants were informed of the outcome of their complaint.</p>	<p>Ensure the UCG policy and procedure regarding complaint management is consistently followed and all complainants are informed of the outcome</p>

				of their complaint. 90 days
<p>Criterion 2.3.1</p> <p>Service providers shall ensure there are sufficient health care and support workers on duty at all times to provide culturally and clinically safe services.</p>	<p>PA Moderate</p>	<p>Due to the effects of a 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 for 24/7 RN cover. Risk mitigation includes the FM, and UCG senior staff providing operational and clinical support after hours, more complex residents are assessed thoroughly to ensure the facility has the resources to manage all their complexities, and a comprehensive recruitment process is underway/ongoing to acquire additional RN resource.</p>	<p>The provider is unable to provide 24/7 cover as per contractual obligations.</p>	<p>Ensure there is 24/7 RN cover as per contractual obligations.</p> <p>90 days</p>
<p>Criterion 2.4.3</p> <p>Professional qualifications shall be validated prior to employment, including evidence of registration and scope of practice for health care and support workers.</p>	<p>PA Low</p>	<p>Staff records sampled and discussion with the FM evidenced that a system was not in place to ensure that the practising certificates, for staff who required them, were reviewed for currency annually.</p>	<p>There was no system in place that ensured all staff who require a practising certificate are checked annually to ensure currency.</p>	<p>Implement a system that ensures all practicing certificates are checked annually and staff maintain currency.</p> <p>90 days</p>
<p>Criterion 2.4.4</p> <p>Health care and support workers shall receive an orientation and induction programme that covers the essential components of the service provided.</p>	<p>PA Low</p>	<p>Review of staff records and discussion with the FM evidenced that not all staff orientation records were completed.</p>	<p>Orientation records were inconsistently completed.</p>	<p>Ensure a system is implemented that ensures all orientation processes are concluded in a timely manner and documentation is complete.</p>

				90 days
<p>Criterion 2.4.5</p> <p>Health care and support workers shall have the opportunity to discuss and review performance at defined intervals.</p>	PA Low	Discussion with FM, review of staff records and interview with staff evidenced that not all staff had a current performance appraisal and there was yet to be a system that ensured staff reviews were conducted at defined intervals.	Not all staff had received a performance review as required.	<p>Ensure a system is implemented that ensures all staff receive a performance review.</p> <p>90 days</p>
<p>Criterion 3.2.1</p> <p>Service providers shall engage with people receiving services to assess and develop their individual care or support plan in a timely manner. Whānau shall be involved when the person receiving services requests this.</p>	PA Low	Whānau input and consultation occurs at the routine three monthly reviews however documentation of family/whānau contact for changes in the resident's condition, changes to medication and following accidents or incidents requires improvement. Review of progress notes and accident and incident reports evidenced that family/whānau contact was inconsistently documented.	Documentation of EPOA / whānau contact following changes in the resident's condition or following accidents and incidents was inconsistent.	<p>Ensure all contact with EPOA / whānau is documented.</p> <p>180 days</p>
<p>Criterion 3.2.4</p> <p>In implementing care or support plans, service providers shall demonstrate:</p> <p>(a) Active involvement with the person receiving services and whānau;</p> <p>(b) That the provision of service is consistent with, and contributes to, meeting the person's assessed needs, goals, and aspirations. Whānau require assessment for support needs as well. This supports</p>	PA Low	Documented interventions and early warning signs in the long-term care plans meet the residents' assessed needs, however the development of short-term care plans for acute problems requires improvement. In three out of five clinical records reviewed the resident had had significant weight loss over a six-month period, no interventions had been implemented, there was no short-term care plan in place to address this issue.	Short term care plans are not developed to address all acute problems.	<p>Ensure short term care plans are developed with interventions to address all acute issues.</p> <p>180 days</p>

<p>whānau ora and pae ora, and builds resilience, self-management, and self-advocacy among the collective; (c) That the person receives services that remove stigma and promote acceptance and inclusion; (d) That needs and risk assessments are an ongoing process and that any changes are documented.</p>				
<p>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.</p>	<p>PA Low</p>	<p>InterRAI re-assessments are completed six monthly and when there is a change in the resident's condition, however six-monthly evaluations of the LTCPs and review of STCPs requires improvement. In two out of five clinical records reviewed the six-monthly evaluation was overdue. One was four months overdue, the other by two months. Short term care that had been developed to address infections had not been reviewed regularly or signed off when the problem resolved.</p>	<p>Long term care plans are not consistently reviewed within the required timeframe. Short term care plans are not consistently reviewed regularly or signed off when an acute issue is resolved.</p>	<p>Ensure that long term and short-term care plans are reviewed as per UCG policy. 180 days</p>

<p>Criterion 4.1.1</p> <p>Buildings, plant, and equipment shall be fit for purpose, and comply with legislation relevant to the health and disability service being provided. The environment is inclusive of peoples' cultures and supports cultural practices.</p>	<p>PA Low</p>	<p>During a walk around of the dementia wing it was noted that there was a hole in the floor of the sensory room which had jagged edges and posed a hazard for the residents.</p>	<p>The sensory room in the dementia wing had a hole in the floor and created a hazard for residents in that area.</p>	<p>Ensure hole in the floor is fixed and the area is maintained and free of hazards.</p> <p>90 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.