

The Ultimate Care Group Limited - Ultimate Care Rose Lodge

Introduction

This report records the results of a Certification Audit of a provider of aged residential care services against the Ngā paerewa Health and disability services standard (NZS8134:2021).

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

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

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

The specifics of this audit included:

Legal entity:	The Ultimate Care Group Limited
Premises audited:	Ultimate Care Rose Lodge
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 13 December 2023 End date: 14 December 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:	19

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
	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
	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 Rose Lodge is part of the Ultimate Care Group Limited. It is certified to provide care for up to 30 residents requiring rest home or hospital level care. Since the previous audit the clinical services role has become vacant and temporary cover is in place until this vacancy is filled. Additionally, the organisation has made changes to the clinical governance/reporting structure since the previous audit. A whanau room has been added to the facility.

This certification audit was conducted against the Ngā Paerewa Health and Disability services standard NZS8134:2021 and the provider contracts with Te Whatu Ora – Southern. The audit process included review of policies and procedures, review of resident and staff records, observations and interviews with staff, residents, whānau, and a general practitioner. Observations were made throughout the audit including the medication round, meal service, laundry services, and the activities programme.

Areas identified as requiring improvement relate to quality and risk, healthcare and support workers information and performance reviews, resident information, the physical environment, resident security, and laundry management.

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.		Subsections applicable to this service are fully attained.
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The service complies with Health and Disability Commission Code of Health and Disability Consumers Rights (the Code). Residents receive services in a manner that considers their dignity, privacy, independence and facilitates informed choice and consent. Care plans accommodate the choices of residents and/or their whānau.

Staff received training in Te Tiriti o Waitangi and cultural safety which was reflected in service delivery. Care was provided in a way that focused on the individual and considered values, beliefs, culture, religion, and relationship status.

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

Hunga mahi me te hanganga | Workforce and structure

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 is the governing body responsible for services provided. The organisation's mission statement and vision were documented and displayed. The Provider has business and quality risk management plans.

The facility manager ensures the management of the facility with the support of the acting clinical services manager. A newly appointed regional manager will support the facility manager once their orientation schedule has been completed.

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

There were human resource policies and procedures that guide practice in relation to recruitment, orientation, and staff management. An organisation wide training schedule was implemented which was appropriate for the residents. Previous staffing deficits have been addressed following a successful recruitment campaign. There was always a sufficient number of staff on site with provision of after-hours support for clinical and operational issues.

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

Ngā huarahi ki te oranga | Pathways to wellbeing

Includes eight subsections that support an outcome where people participate in the development of their pathway to wellbeing, and receive timely assessment, followed by services that are planned, coordinated, and delivered in a manner that is tailored to their needs.		Subsections applicable to this service are fully attained.
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Information was provided in accessible formats to residents and their whānau on entry. 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 admission.

InterRAI assessments were used to identify residents' needs and these were completed within the required timeframes. The general practitioner or nurse practitioner completed a medical assessment on admission and reviews occurred thereafter on a

regular basis. Long term care plans were developed and implemented within the required timeframes. Resident files sampled demonstrated evaluations were completed at least six-monthly. Handovers between shifts guided continuity of care and teamwork was encouraged.

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

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

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

The food service met the nutritional needs of the residents. All meals were prepared on-site. Residents and family/whānau confirmed satisfaction with the 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 medium or high risk and/or unattained and of low risk.
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The organisation maintains an appropriate environment. A reactive and preventative maintenance programme was implemented. External areas provide safe seating and shade.

Resident rooms were of an appropriate size for the safe use and manoeuvring of mobility aids and provision of care. Lounge and dining areas provided spaces for residents and their visitors. A new whānau room has been developed since the last audit providing space for residents to partake in cultural activities. Communal and individual spaces were maintained at a comfortable temperature.

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

Emergency and security arrangements were outlined to all people using the services and/or entering the facility. There was a staff member with a current first aid certificate on duty at all times.

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.		Some subsections applicable to this service are partially attained and of low risk.
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The infection prevention and antimicrobial stewardship programmes were appropriate to the size and complexity of the service and included policies and procedures to guide staff.

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

There were organisational COVID-19 prevention strategies in place including a pandemic plan. There had been no outbreaks since the last audit.

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.
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Restraint minimisation and safe practice policies and procedures were in place. Restraint minimisation was overseen by the restraint coordinator. On the day of the audit, there were no residents using a restraint, there had been no restraint used since 2021. Restraint was only used as a last resort when all other options had been explored.

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

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Subsection	0	20	0	4	3	0	0
Criteria	0	159	0	5	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.

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

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

Subsection with desired outcome	Attainment Rating	Audit Evidence
<p>Subsection 1.1: Pae ora healthy futures</p> <p>Te Tiriti: Māori flourish and thrive in an environment that enables good health and wellbeing.</p> <p>As service providers: We work collaboratively to embrace, support, and encourage a Māori worldview of health and provide high-quality, equitable, and effective services for Māori framed by Te Tiriti o Waitangi.</p>	<p>FA</p>	<p>Staff received training in cultural safety at orientation. The organisation had developed a cultural safety module that was provided as part of the education programme. It defines and explains cultural safety and its importance including Te Tiriti o Waitangi. However, training records reviewed were incomplete rendering it difficult to ascertain how many staff had completed this (refer 2.3.4).</p> <p>The organisation has a Māori health action plan that recognises the principles of Te Tiriti o Waitangi and describes how the Ultimate Care Group (UCG) responds to Māori cultural needs in relation to health and illness. The health plan outlines that the recruitment of Māori staff shall be encouraged, and the facility manager (FM) outlined examples of how this was implemented. The plan describes the aims of UCG to ensure outcomes for Māori are positive and equitable. Strategies include, but are not limited to, identifying priority areas for leadership to focus upon, and increasing the knowledge base across the organisation underpinned by Mātauranga Māori. The document outlines the importance of ensuring any resident who identifies as Māori would have the opportunity to have whānau involved in their care. There were residents residing in the facility at time of audit who identified as Māori.</p> <p>The Provider has established formal links with local iwi of the region at</p>

		Murihiku marae and Te Rau marae as outlined by the facility manager (FM).
<p>Subsection 1.2: Ola manuia of Pacific peoples in Aotearoa</p> <p>The people: Pacific peoples in Aotearoa are entitled to live and enjoy good health and wellbeing.</p> <p>Te Tiriti: Pacific peoples acknowledge the mana whenua of Aotearoa as tuakana and commit to supporting them to achieve tino rangatiratanga.</p> <p>As service providers: We provide comprehensive and equitable health and disability services underpinned by Pacific worldviews and developed in collaboration with Pacific peoples for improved health outcomes.</p>	FA	<p>The Pacific plan outlines the organisations commitment to providing culturally safe care. It defines the cultural and spiritual beliefs of Pacific peoples. The policy was underpinned by Pacific models of care with UCG senior staff accessing information to support the plan from Pacific communities. The plan outlines how the organisation will endeavour to achieve equity through partnerships and collaboration. The FM and activities coordinator outlined what Pacific community connections were in place with the local Pacific Christian community.</p> <p>The organisation has developed a strategy that ensures a Pacific health and wellbeing workforce was recruited and retained across the organisation. The FM outlined how this was implemented.</p> <p>There were no residents that identified as Pacific residing at the facility at time of audit.</p>
<p>Subsection 1.3: My rights during service delivery</p> <p>The People: My rights have meaningful effect through the actions and behaviours of others.</p> <p>Te Tiriti:Service providers recognise Māori mana motuhake (self-determination).</p> <p>As service providers: We provide services and support to people in a way that upholds their rights and complies with legal requirements.</p>	FA	<p>The Code of Health and Disability Services Consumers' Rights (the Code) was on display throughout the facility written in English and Te reo Māori.</p> <p>Staff discussed the Code and gave examples of how they met the Code when providing day to day care. Observation during the audit confirmed that the provision of care was provided in accordance with the Code. Staff records sampled evidenced that training pertaining to the Code formed part of the orientation schedule. Residents and/or whānau were provided written information about the Code on admission and stated they were provided opportunities to discuss their rights. Further discussion evidenced that they had been consulted about their care plan and were involved in decisions pertaining to their care.</p> <p>Staff outlined they were aware of the advocacy service and how to support residents contact the national advocacy service. Contact details were available on posters throughout the facility. The FM outlined that representatives from the national advocacy service meet face to face</p>

		<p>with residents periodically.</p> <p>Policy and practice include ensuring that all residents, including any Māori residents, right to self-determination was upheld and they can practise their own personal beliefs and values. The Māori health action plan identifies how UCG responds to Māori cultural needs in relation to health and illness.</p>
<p>Subsection 1.4: I am treated with respect</p> <p>The People: I can be who I am when I am treated with dignity and respect.</p> <p>Te Tiriti: Service providers commit to Māori mana motuhake.</p> <p>As service providers: We provide services and support to people in a way that is inclusive and respects their identity and their experiences.</p>	<p>FA</p>	<p>The Provider ensured that residents and whānau were involved in planning and care which was inclusive of discussions and choices regarding maintaining independence. Resident, whānau and staff interviews, plus observation, confirmed that individual religions, social preferences, values, and beliefs were identified and upheld. These were also documented in resident records sampled.</p> <p>The Provider had policies and procedures that were aligned to the requirements of the Privacy Act and Health Information Privacy Code to ensure that residents rights to privacy and dignity were upheld. The FM outlined that the team were notified of a breach of privacy recently and that this was remedied swiftly. A corrective action plan was created, staff received additional education in privacy, and they were instrumental in finding a solution to the problem to ensure the chance of further breaches were minimised. Residents, whānau, and staff interviews, plus observation, evidenced that staff knock on doors before entering, use signage on residents' doors to indicate that cares are in progress, and confidentiality was maintained when staff were holding conversations that were personal in nature.</p> <p>Staff receive training in Te Tiriti o Waitangi and tikanga best practice and have additional resources available to provide ongoing guidance. However, the education records were incomplete making it difficult to ascertain how many had completed this and when their next training was due (refer 2.3.4). Staff were encouraged to use basic greetings in te reo Māori with correct pronunciations displayed in poster form throughout the facility.</p> <p>The organisation supports tangata whaikaha to do well with documentation outlining how staff will support with goal setting and</p>

		achievement with all aspects of service delivery.
<p>Subsection 1.5: I am protected from abuse</p> <p>The People: I feel safe and protected from abuse.</p> <p>Te Tiriti: Service providers provide culturally and clinically safe services for Māori, so they feel safe and are protected from abuse.</p> <p>As service providers: We ensure the people using our services are safe and protected from abuse.</p>	FA	<p>There was policy that includes definitions, guidelines, and responsibilities for staff to report alleged or suspected abuse. Staff received orientation and mandatory training in abuse and neglect. Interviews confirmed staff awareness of their obligations to report any incidences of suspected abuse. Staff and whānau confirmed there was no evidence of abuse or neglect.</p> <p>The admission agreement signed prior to occupation provides clear expectations regarding management responsibilities of personal property and finances. Residents and/or their whānau provide consent for the administrator to manage the residents comfort funds. Discussion with the administrator and review of documentation evidenced that appropriate systems were in place that ensured the safe management of resident's comfort funds. Residents and/or their whānau provided further confirmation that resident property was respected.</p> <p>There were policies and procedures to ensure that the environment was free from discrimination, racism, coercion, harassment, and financial exploitation. They provide guidance to staff on how this was prevented, and where suspected, the reporting process.</p> <p>Staff were required to sign and abide by the UCG code of conduct and professional boundaries agreement. All staff records sampled evidenced that these were signed. Staff mandatory training included maintaining professional boundaries. Discussion with staff confirmed their understanding of professional boundaries relevant to their perspective roles. Residents and/or their whānau confirmed that professional boundaries were maintained.</p> <p>Residents described how they feel safe living in the facility and were complimentary regarding the level of care received. Whānau provided further evidence that they feel comfortable to raise any issues and discussions were free and open.</p> <p>A review of documentation, and discussion with the clinical coach for the region who is currently providing clinical services in the absence of a clinical services manager (CSM), outlined that the Māori model of care</p>

		<p>Te Wheke has been implemented within the facility. Education was ongoing to ensure staff were understanding of the model and were comfortable to utilise it within all aspects of care delivery. Posters placed in clinical areas provided additional information about Te Wheke and use of the model within resident records was evident.</p>
<p>Subsection 1.6: Effective communication occurs</p> <p>The people: I feel listened to and that what I say is valued, and I feel that all information exchanged contributes to enhancing my wellbeing.</p> <p>Te Tiriti: Services are easy to access and navigate and give clear and relevant health messages to Māori.</p> <p>As service providers: We listen and respect the voices of the people who use our services and effectively communicate with them about their choices.</p>	<p>FA</p>	<p>There was policy to ensure that residents and their whānau have the right to comprehensive information supplied in a way that was appropriate and considered specific language requirements and disabilities. The FM confirmed that where required interpreters were accessed from Te Whatu Ora – Southern. At time of audit there were no residents who required an interpreter.</p> <p>Resident records sampled evidenced that other healthcare agencies were involved in resident care providing additional assessments and treatment regimens as required.</p> <p>There was policy which required whānau be advised within 24 hours of an adverse event occurring. Review of accident and incident information and staff and whānau interviews confirmed that timeframes were met, and open disclosure had occurred following an event involving a resident.</p> <p>Two monthly resident meetings were scheduled, however incomplete documentation regarding when meetings were held, topics/issues raised, and progress made regarding had the issues been resolved were difficult to ascertain (refer 2.2.3). Meetings were advertised in the activities planner with reminders of what is coming up placed on noticeboards throughout the facility. Residents and whānau advised they attend resident meetings and were positive about the outcomes of these. The FM advised an advocate from the national advocacy service can be present at meetings periodically. Copies of the menu and activities plan were available to residents and their whānau.</p>
<p>Subsection 1.7: I am informed and able to make choices</p> <p>The people: I know I will be asked for my views. My choices will</p>	<p>FA</p>	<p>The informed consent policy was in line with the Code. The policy outlined how staff were to ensure that a resident who has capacity/competence to consent to a treatment or procedure had been</p>

<p>be respected when making decisions about my wellbeing. If my choices cannot be upheld, I will be provided with information that supports me to understand why.</p> <p>Te Tiriti: High-quality services are provided that are easy to access and navigate. Providers give clear and relevant messages so that individuals and whānau can effectively manage their own health, keep well, and live well.</p> <p>As service providers: We provide people using our services or their legal representatives with the information necessary to make informed decisions in accordance with their rights and their ability to exercise independence, choice, and control.</p>		<p>given sufficient information to enable them to arrive at a reasoned and voluntary decision. Staff confirmed additional guidance was provided for staff in the event a resident is unable to provide consent. Competence to provide informed consent was determined by the general practitioner (GP).</p> <p>Staff received training on informed consent and choice during their orientation. Evidence of completion was evident in staff records sampled. All staff interviewed were cognisant of the procedures to uphold informed consent. The resident pack included information regarding consent. The acting CSM or admitting registered nurse (RN) explains and discusses informed consent to residents and/or their whānau during the admission process to ensure understanding. This included consent for resuscitation and advanced directives. All resident records sampled had signatures for consent with Enduring Power of Attorney (EPoA) signatures noted for those residents who were assessed as not being competent. Additional consents included student nurse participation and resident photos.</p> <p>The informed consent policy acknowledges Te Tiriti o Waitangi and the impact of culture and identity on the determinants of the health and wellbeing of Māori. It required health professionals to recognise these as relevant when issues of health care for Māori residents arises. The FM advised that additional support could be provided for Māori residents if required from Te Whatu Ora – Southern and the links in place with Māori in the community.</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>	<p>FA</p>	<p>The organisation had a complaints process that aligned with consumer rights legislation. The process was confirmed to be transparent and equitable. The complaint process was made available in the admission agreement and explained by the admitting nurse. Complaint forms were easily accessed within the facility and UCG website enables complaints to be logged online. Interviews with the FM, staff, residents, and whānau confirmed they were aware of the complaints process and were encouraged to raise any concerns and provide feedback. The FM explained that support can be provided to assist Māori residents to navigate the complaints process via Te Whatu Ora – Southern or the</p>

		<p>links in place with Māori in the community.</p> <p>The FM is responsible for managing complaints. All complaints received are logged on the electronic system. Evidence relating to the investigation of the complaint was attached to the file including evidence of when the complainant was informed of the outcome. All complaints received had been closed to the satisfaction of the complainant except one which was only recently received.</p> <p>The FM advised there had been one Health and Disability Commission (HDC) complaint received since the last audit. The Provider has supplied all requested information and was awaiting the outcome at time of 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 Rose Lodge is part of Ultimate Care Group (UCG) which is a New Zealand registered company. There is governance structure in place which monitors compliance with legislative, contractual, and regulatory requirements. There was Māori representation at governance level providing guidance to the organisation to ensure actions were embedded across the organisation that enacts the principles of Te Tiriti o Waitangi. The national relationship manager has advised the core competencies executive management are required to demonstrate including undertaking the organisation’s obligations under Te Tiriti o Waitangi, and cultural safety. It was reported there had been no changes to the governing structure since the last audit. An executive team provides direction to the Provider.</p> <p>The annual strategic business plan has key outcomes which are resident centred, such as resident satisfaction, health and safety, complaints, education, and fiscal stability. These were monitored at board meetings. Review of previous resident and whānau survey results evidenced that the organisation values and prioritises input into service delivery from people receiving care.</p> <p>The organisation has a documented strategy plan incorporating vision, mission, and values statements. The document was reviewed annually by the executive team and the board. The organisations values were displayed in the facility and were included within information available to residents and whānau.</p>

	<p>The Māori health action plan describes how the organisation was aware of barriers and inequities for Māori and how to reduce them. Staff are encouraged to learn and use basic Māori greetings/phrases and continue to upskill in Māori tikanga. Whānau are encouraged to have input into service improvement as confirmed by staff, residents and whānau.</p> <p>The UCG management team has commenced a change to the clinical governance structure with the removal of regional clinical managers and the introduction of clinical coaches to provide clinical support to all UCG facilities. The clinical coach for the region was acting as clinical services manager whilst the role is vacant and provided support to the FM for the audit.</p> <p>The FM has a background in diversional therapy. The FM was the activities coordinator in another UCG facility prior to being appointed. The FM reports to the regional manager (RM) who is newly appointed to the role and currently undergoing the organisational orientation. The acting CSM has a broad range of experience including acute care within secondary services and aged care management.</p> <p>The organisation has implemented robust systems to support the quality and risk management structure with a wide range of information gathered to inform service delivery. The executive team provides the necessary resources keeping staff informed and providing support as evidenced by staff interviews.</p> <p>The Māori health action plan outlines the organisations commitment to improving outcomes for tangata whaikaha with the goals and actions required described and the support required to achieve aspirations and reduce barriers. The organisation continues to focus on the need to prioritise the building of relationships with Māori disability stakeholders.</p> <p>The Provider is certified to provide rest home and hospital level care for up to 30 residents. Occupancy on day of audit comprised of 16 residents assessed as requiring rest home level care and three residents assessed as requiring hospital level of care. This was inclusive of one resident under an Accident Compensation Corporation (ACC) contract. All other residents were under the aged residential care contract (ARCC).</p> <p>The Provider holds contracts with Te Whatu Ora – Southern to deliver</p>
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		rest home care and hospital aged related residential levels of care. The Provider had no residents with occupational right agreements.
<p>Subsection 2.2: Quality and risk</p> <p>The people: I trust there are systems in place that keep me safe, are responsive, and are focused on improving my experience and outcomes of care.</p> <p>Te Tiriti: Service providers allocate appropriate resources to specifically address continuous quality improvement with a focus on achieving Māori health equity.</p> <p>As service providers: We have effective and organisation-wide governance systems in place relating to continuous quality improvement that take a risk-based approach, and these systems meet the needs of people using the services and our health care and support workers.</p>	<p>PA Moderate</p>	<p>The organisation has an annually reviewed, executive team approved, quality and risk management plan. The plan outlines the identified internal and external organisational risks and the quality framework utilised to promote continuous quality improvement. There were policies, and procedures and associated systems to ensure that the organisation meets accepted good practice and adheres to relevant standards relating to the Health and Disability Services (Safety) Act 2001.</p> <p>There was an implemented annual schedule of internal audits. Areas of non-compliance including the implementation of a corrective action plan and sign off was the responsibility of the acting CSM. A reporting tool captures a broad range of information across all UCG facilities.</p> <p>Two staff members have been appointed as health and safety representatives. The Provider has made a commitment to ensuring all staff were aware of the importance of health and safety with a continued focus upon minimising accidents or incidents.</p> <p>The Provider had a set schedule of meetings in place including quality, health and safety, staff and residents, however process was not always followed that ensured all relevant information was documented or shared.</p> <p>The organisation follows the UCG adverse event reporting policy for external and internal reporting. Completed section 31 notifications were completed weekly when the Provider was unable to provide registered nurse (RN) cover as per contractual obligations.</p> <p>The organisation's commitment to providing high quality health care for Māori was stated within the Māori health action plan and policy. This included the provision of appropriate education for staff, supporting leaders to champion high quality health care and ensuring that resident centred values guide clinical decision making. The organisations progress in these domains was followed at executive and board level and improvements made when progress was less than optimal.</p>

<p>Subsection 2.3: Service management</p> <p>The people: Skilled, caring health care and support workers listen to me, provide personalised care, and treat me as a whole person.</p> <p>Te Tiriti: The delivery of high-quality health care that is culturally responsive to the needs and aspirations of Māori is achieved through the use of health equity and quality improvement tools.</p> <p>As service providers: We ensure our day-to-day operation is managed to deliver effective person-centred and whānau-centred services.</p>	<p>PA Low</p>	<p>The organisations staffing policy includes the rationale for staff rostering and skill mix inclusive of a facility managers roster allocation to ensure safe staffing levels were maintained. Review of rosters evidenced that unplanned absences were covered appropriately by part time staff working additional hours.</p> <p>The FM worked 40 hours per week and provided after hours support for operational issues. The acting CSM worked for three days per week and provided after hours clinical support. Current RN levels ensures the CSM is not required to work on the floor. Additional clinical support was provided by facility RNs and UCG head office providing senior staff on a rostered basis when the facility was unable to provide this. The morning shift comprised of one RN and three caregivers across the whole facility, the afternoon shift had one RN and two care givers, and the night shift comprised of one RN or international qualified nurse (IQN) and a care giver. Nonclinical staff included housekeeping, laundry, kitchen and maintenance personnel. Laundry and cleaning staff were rostered for part time hours across the week.</p> <p>Interviews with residents, whānau and staff advised they were not aware of any staffing issues impacting on residents or service delivery. Previous staffing difficulties have been addressed due to a successful recruitment campaign. Review of rosters evidenced that each week there was one shift without an RN which was filled by an IQN. All IQNs, had an annual practising certificate (APC) from their country of origin, have current medication competencies, and follow the UCG STOP and WATCH acute deterioration assessment policy/procedure which is inclusive of the guidelines for the escalation pathway when required for residents of concern. A section 31 notification was submitted each week notifying of the RN shortage. There were four RNs employed across the facility.</p> <p>There was an implemented training programme. Staff competencies, training and education scheduled were relevant to the needs of aged care residents. However, the records for attendance and dates the next training was due were incomplete (referrer 2.3.4). Current cultural safety training schedule provides staff with resources to support their practice to achieve equitable health outcomes. Two RNs have completed</p>

		<p>InterRAI training.</p> <p>The Provider collects both staff and resident ethnicity data via an online platform and forms part of the monthly report compiled for the board. Support systems promote staff wellbeing, and a positive work environment was confirmed by staff. Employee support services were available when required.</p>
<p>Subsection 2.4: Health care and support workers</p> <p>The people: People providing my support have knowledge, skills, values, and attitudes that align with my needs. A diverse mix of people in adequate numbers meet my needs.</p> <p>Te Tiriti: Service providers actively recruit and retain a Māori health workforce and invest in building and maintaining their capacity and capability to deliver health care that meets the needs of Māori.</p> <p>As service providers: We have sufficient health care and support workers who are skilled and qualified to provide clinically and culturally safe, respectful, quality care and services.</p>	<p>PA Low</p>	<p>The organisations human resource systems policies and procedures outline the principles of good employment practice and the Employment Relations Act 2000. However, review of staff records confirmed the UCG policy and procedure was inconsistently followed. For example, staff records sampled were incomplete with varying information missing or insecure.</p> <p>The recruitment process includes police vetting, reference checks, and validation of annual practising certificates/qualifications. Current practicing certificates were sighted for those staff and contractors that required these. Job descriptions include accountabilities/responsibilities specific to the role with a clear outline of who they are to report to. Personnel involved in driving the van used for resident outings held drivers' licences without any driving convictions and first aid certificates.</p> <p>There was a documented and implemented orientation programme and staff records evidenced that orientation was completed. Orientation covered the essential components of service delivery with specifics relating to their roles included. Staff confirmed completing this and advised it was appropriate to their role. Should the Provider utilise agency nursing staff there was separate policy and plan for their orientation if required.</p> <p>Annual performance reviews were completed for all staff requiring these and three-monthly reviews had been carried out for newly appointed staff, however some clinical staff had been reviewed by a non-clinical manager.</p> <p>Staff interview and review of documentation evidenced that staff ethnicity data was collected, and review of staff records provided additional information this was in place.</p>

		The FM confirmed that a debrief process could be put in place when required.
<p>Subsection 2.5: Information</p> <p>The people: Service providers manage my information sensitively and in accordance with my wishes.</p> <p>Te Tiriti: Service providers collect, store, and use quality ethnicity data in order to achieve Māori health equity.</p> <p>As service provider: We ensure the collection, storage, and use of personal and health information of people using our services is accurate, sufficient, secure, accessible, and confidential.</p>	PA Low	<p>Resident's records and medication charts were managed electronically. Resident information including progress notes was entered into the residents' records in an accurate and timely manner. The name and designation of the author was identifiable. Residents' notes were completed every shift.</p> <p>There were policies and procedures in place to ensure the privacy and confidentiality of resident information. Staff confirmed awareness of their obligation to maintain confidentiality of all resident information. Resident care and support information can be accessed in a timely manner and was protected from unauthorised access.</p> <p>Records include information obtained on admission and information supplied from resident's whānau where applicable. Other information including assessments and reports from other health professionals were integrated however information from general practitioners (GP) was being entered into two different electronic systems.</p> <p>The Provider gathers information on admission regarding a resident's ethnicity which was reported through to UCG head office. The Provider was not required to gather data regarding the national health index (NH).</p>
<p>Subsection 3.1: Entry and declining entry</p> <p>The people: Service providers clearly communicate access, timeframes, and costs of accessing services, so that I can choose the most appropriate service provider to meet my needs.</p> <p>Te Tiriti: Service providers work proactively to eliminate inequities between Māori and non-Māori by ensuring fair access to quality care.</p> <p>As service providers: When people enter our service, we adopt a person-centred and whānau-centred approach to their care. We focus on their needs and goals and encourage input from whānau. Where we are unable to meet these needs, adequate</p>	FA	<p>On enquiry, an information booklet detailing entry criteria was provided to prospective residents and their whānau. This information was also available on the internet.</p> <p>On admission residents and their whānau were provided with written and verbal information with any questions raised answered by staff. Admission packs provided comprehensive information written in plain language, citing key messages. The information was also available in te reo Māori. Interpreters were available via Te Whatu Ora Southern and used as required to ensure resident understanding is achieved. Staff interviewed reported they could access interpreter services if required.</p> <p>There were documented entry policies and processes in place and staff</p>

<p>information about the reasons for this decision is documented and communicated to the person and whānau.</p>		<p>interviewed were able to discuss these in detail. Review of residents' files confirmed that entry to service complied with entry criteria. Information relating to admission, discharge and decline rates was analysed by the board via the monthly reporting system.</p> <p>Residents and whānau interviewed reported they were treated with respect and kept informed throughout the admission process and understood the rationale for information required during the process, for example Enduring Power of Attorney (EPOA) status.</p> <p>The Provider had a process in place if access was declined. It required that when a person was declined access to the service, the person, their whānau and the referring agency were informed of the decline. Alternative services when possible were offered and documentation of reason is maintained in internal files. A person would be declined entry if not within the scope of the service or if a bed was not available. The acting clinical services manager (CSM) explained that entry was declined for persons who had complex medical needs that could not be met due to recent staffing shortages. Negotiations with Te Whatu Ora regarding hospital level admissions is ongoing now staffing has improved. Declining of admissions was reported as part of the UCG monthly report.</p> <p>The admission policy required the collection of information that included but is not limited to ethnicity; spoken language; interpreter requirements; iwi; hapu; religion; and referring agency. Interviews with residents and whānau and review of records confirmed the admission process was completed in a timely manner. Ethnicity, including Māori, was being collected and analysed. Rose Lodge had established relationships with the iwi of the region at Murihiku marae and Te Rau Aroha marae, and with local Māori health providers, for example, Te Korowai Hau Ora (mental health), Te Huinga Tahī (physical care) and Ararua whānau services to ensure appropriate support for tāngata whenua.</p>
<p>Subsection 3.2: My pathway to wellbeing</p> <p>The people: I work together with my service providers so they know what matters to me, and we can decide what best supports my wellbeing.</p>	<p>FA</p>	<p>Ultimate Care Group has developed a model of care specific to older persons. Staff interviewed described the model of care and how the model informed care delivery. Resident care plans were developed using an electronic system. RNs were responsible for all residents'</p>

<p>Te Tiriti: Service providers work in partnership with Māori and whānau, and support their aspirations, mana motuhake, and whānau rangatiratanga.</p> <p>As service providers: We work in partnership with people and whānau to support wellbeing.</p>	<p>assessments, care planning and evaluation of care.</p> <p>Initial care plans were developed with the residents/next of kin/EPOA consent within the required timeframe. They were based on data collected during the initial nursing assessments and on information from pre-entry assessments completed by the needs assessment co-ordination service (NASC) or other referral agencies. The assessments included information about, but not limited to, the resident's medical history, pain, nutrition, mobility, skin condition, early warning signs (EWS), cultural needs, spiritual wellbeing, and documentation of the resident's life experience. Assessments sampled had been completed in consultation with the resident and whānau. Residents interviewed confirmed assessments were completed according to their needs and in the privacy of their bedrooms.</p> <p>The residents' activities assessments were completed by the activity coordinators in conjunction with the RN following the residents' admission. Information on residents' interests, family/whānau, and previous occupations was gathered during the 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 and were part of the formal six-monthly multidisciplinary review process.</p> <p>The individualised long term care plans (LTCPs) were developed with information gathered during the initial assessments and from the interRAI assessment. Documented interventions and early warning signs met the residents' assessed needs. Short term care plans were developed for acute problems for example infections, pain, post-fall care or weight loss.</p> <p>The initial medical assessment was completed by the residents' general practitioner (GP) or nurse practitioner (NP) within the required timeframe following admission. Residents had reviews by the GP or NP within required timeframes and when their health status changed. There was documented evidence of the exemption from monthly GP/NP visits when the resident's condition was considered stable. The GP interviewed confirmed that there was good communication with the service, they</p>
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	<p>were informed of concerns in a timely manner and instructions given were followed. The Provider had access to an after-hours service. A physiotherapist visits the facility weekly and reviewed residents referred by the acting CSM or RNs. A podiatrist visits the facility every six weeks.</p> <p>Staff interviewed and education records sighted confirmed that staff had access to cultural training (refer 2.3.4). The provision of care reflected in the care plan was consistent with, and contributed to, meeting the residents assessed needs, goals, and aspirations. Support was identified for whānau. Staff discussed service provision to include providing services free from stigma and those which promote acceptance and inclusion.</p> <p>There was evidence of wound care products available. The review of the wound care plans evidenced wounds were assessed in a timely manner and reviewed at appropriate intervals. Photos were taken where this was required. Where wounds required additional specialist input, this was initiated.</p> <p>Nursing progress notes are recorded and maintained in the electronic resident record; medical notes were documented in either the resident's electronic record or in the electronic medication management system (refer finding 2.5.1). Monthly observations such as weight and blood pressure were completed and were up to date. Neurological observations were recorded following all unwitnessed falls. Any changes in the resident's condition are documented. There were escalation processes in place for clinical change and staff were able to discuss these. Clinical records sampled confirmed that where escalation had occurred this had been documented appropriately. Interviews with medical and nursing staff confirmed the process was undertaken consistently.</p> <p>Policies and protocols are in place to ensure continuity of service delivery. Staff interviews confirmed they are familiar with the needs of all residents and that they have access to the supplies and products they require.</p> <p>Resident care was evaluated on each shift, reported at handover and in the progress notes. If any change was noted and reported to the RN. Long term care plans were formally evaluated every six months in conjunction with the interRAI re-assessments and when there was a</p>
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		<p>change in the resident's condition. Evaluations were documented by the RN and included the degree of achievement towards meeting desired goals and outcomes. The clinical records sampled demonstrated that reviews of the resident care were ongoing. Handover meetings between each shift ensured residents progress towards meeting identified goals was discussed. Where progress was different from that expected, changes to the resident's care plan were made and actions implemented. This was verified in clinical files sampled and during staff and resident interviews.</p> <p>The organisation had developed policies and procedures in conjunction with the other relevant services and organisations to support tāngata whaikaha. These services and organisations had representation from tāngata whaikaha. Interviews with staff confirmed that staff were able to facilitate tāngata whaikaha access to information should this be required.</p> <p>A Māori health care plan was used for residents identifying as Māori. The care plan guided staff in gathering information and documenting the support required to meet the needs of residents who identified as Māori. Staff discussed their understanding of support required for Māori and whānau to identify their own pae ora outcomes in their care or support plan, how these could be achieved and documented.</p>
<p>Subsection 3.3: Individualised activities</p> <p>The people: I participate in what matters to me in a way that I like.</p> <p>Te Tiriti: Service providers support Māori community initiatives and activities that promote whanaungatanga.</p> <p>As service providers: We support the people using our services to maintain and develop their interests and participate in meaningful community and social activities, planned and unplanned, which are suitable for their age and stage and are satisfying to them.</p>	FA	<p>The residents' activities programme was developed and implemented by two activities co-ordinators. Activities for the residents were provided Monday to Friday. At weekends movies, bingo, puzzles and quizzes were available. The activities programme was displayed in the communal area and on the individual resident notice boards. The programme provided variety in the content and included a range of activities which incorporated education, leisure, cultural, spiritual and community events. For those residents who chose not to take part in the programme, one on one visits from the activity co-ordinators occurred regularly.</p> <p>The programme was culturally diverse and tailored to the needs of the residents. Activities for the residents have included visits from kapa haka groups, Waitangi Day and Matariki celebrations, using pois in music and exercise sessions, armchair travel, celebrating Diwali, visits from Filipino</p>

		<p>dancers and specific cultural days where staff members from different cultures talk about and share food from their culture. The Provider has developed links to a local kindergarten and schools. Whānau participation in the programme is encouraged. Church services were held monthly. Regular van outings into the community were arranged.</p> <p>Staff interviews confirmed that they had completed Māori cultural awareness education and that the involvement of Māori residents in the delivery of services is encouraged.</p> <p>Regular resident meetings are held and include discussion around activities. The residents and whānau reported satisfaction with the activities provided. Over the course of the audit residents were observed engaging and enjoying a variety of activities.</p>
<p>Subsection 3.4: My medication</p> <p>The people: I receive my medication and blood products in a safe and timely manner.</p> <p>Te Tiriti: Service providers shall support and advocate for Māori to access appropriate medication and blood products.</p> <p>As service providers: We ensure people receive their medication and blood products in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>A current medication management policy identified all aspects of medicine management in line with relevant legislation, standards, and guidelines. A safe system for medicine management using an electronic system was observed. Prescribing practices were in line with legislation. The required three-monthly reviews by the GP were recorded electronically. Resident allergies and sensitivities were documented on the electronic medication chart and in the resident's electronic record.</p> <p>The service used pharmacy pre-packaged medicines that were checked by the RN on delivery. There was a supply of stock medication which was used 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 temperatures and medication room temperatures were monitored as per UCG policy and were within the required range.</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>The staff observed administering medication demonstrated knowledge and at interview demonstrated clear understanding of their roles and responsibilities related to each stage of medication management. The</p>

		<p>RN oversaw the use of all 'as required' (PRN) medications and documentation made regarding effectiveness was sighted.</p> <p>Current medication competencies were evident in staff files. Education for residents regarding medications occurred on a one-to-one basis by the GP, acting CSM or RN. Medication information for residents and whānau could be accessed from the contracted pharmacy and from Medsafe as needed.</p> <p>There was a policy in place to facilitate the safe self-administration of medication where appropriate, however there were no residents were self-administering medication. There were no standing orders in place.</p> <p>The UCG medication policy describes use of over the counter (OTC) medications and traditional Māori medications and the requirement for these to be discussed with, and approved by, a medical practitioner. Interview with the GP, acting CSM and RN confirmed that where over the counter or alternative medications were being used, they were added to the medication chart following discussion with the resident and/or their whānau. The GP confirmed if a Māori resident wished to use complementary Māori medications this would be discussed with the resident and their whānau prior to approval being given.</p>
<p>Subsection 3.5: Nutrition to support wellbeing</p> <p>The people: Service providers meet my nutritional needs and consider my food preferences.</p> <p>Te Tiriti: Menu development respects and supports cultural beliefs, values, and protocols around food and access to traditional foods.</p> <p>As service providers: We ensure people's nutrition and hydration needs are met to promote and maintain their health and wellbeing.</p>	<p>FA</p>	<p>A nutritional assessment was undertaken by an RN for each resident on admission to identify dietary requirements, allergies / sensitivities, and preferences. The nutritional profiles were communicated to the kitchen staff and updated when a resident's dietary needs change. Diets were modified as needed and the cook confirmed awareness of the dietary needs, allergies/ sensitivities, likes and dislikes of residents. These were accommodated in daily meal planning.</p> <p>All meals were prepared on site and served in the dining room or in the residents' rooms as requested. Residents could participate in food preparation as part of the activity programme. The temperature of food served was recorded. Residents were observed to be given sufficient time to eat their meal and assistance was provided when necessary. Residents and families/whānau interviewed stated that they were satisfied with the meals provided.</p>

		<p>The food service is provided in line with recognised nutritional guidelines for older people. The seasonal menu has been approved by a New Zealand Registered Dietician. The food control plan expiry date is June 2024.</p> <p>The kitchen was observed to be clean, and the cleaning schedules sighted. All aspects of food procurement, production, preparation, storage, delivery, and disposal sighted at the time of the audit complied with current legislation and guidelines. The cook was responsible for purchasing the food to meet the requirements of the menu plans. Food was stored and labelled appropriately in fridges and freezers. Temperatures of fridges and the freezer are monitored and recorded daily. Dry food supplies were stored in the pantry and rotation of stock occurs. All dry stock containers were labelled and dated.</p> <p>Discussion and feedback on the menu and food provided was sought individually by the cook, at the residents' meetings and in the annual residents' survey. For Māori residents' information is gathered regarding nutritional needs and preferences during the initial assessment and during the development of their individual Māori health plan. The cook explained that Māori residents could request culturally specific food, and any request would be accommodated following discussion with the resident and/or whānau.</p>
<p>Subsection 3.6: Transition, transfer, and discharge</p> <p>The people: I work together with my service provider so they know what matters to me, and we can decide what best supports my wellbeing when I leave the service.</p> <p>Te Tiriti: Service providers advocate for Māori to ensure they and whānau receive the necessary support during their transition, transfer, and discharge.</p> <p>As service providers: We ensure the people using our service experience consistency and continuity when leaving our services. We work alongside each person and whānau to provide and coordinate a supported transition of care or support.</p>	<p>FA</p>	<p>There were policies and processes that guide the transition, transfer, and discharge of residents. Staff interviewed were aware of the procedures required and discussed these during the audit.</p> <p>Records reviewed evidenced that transition, discharge, or transfer was managed in a planned and coordinated manner and included ongoing consultation with residents and whānau. The Provider facilitated access to other medical and non-medical services. Residents and/or whānau were advised of options to access other health and disability services, social support or kaupapa Māori agencies if indicated or requested. Information regarding some of these services was on the residents' noticeboard. Staff interviewed were able to discuss other health and disability services and/or social support agencies that were suitable. When needed, referrals were sent to ensure other health services,</p>

		<p>including specialist care was provided. Referral forms and documentation were maintained on resident files. Referrals were regularly followed up. Communication records sampled confirmed whānau were kept informed of the referral process.</p> <p>Interview with the acting CSM and review of residents' files confirmed there was open communication between services, the resident, and whānau. Relevant information was documented and communicated to health providers. For residents who are discharged into the community discharge documentation is tailored to the individual circumstances and can include a medication chart and a care summary generated by the electronic system. For transfers to hospital the Te Whatu Ora Southern transfer form was used, at their request. Additional documentation included the resident's medication chart, resuscitation status and EPOA information.</p>
<p>Subsection 4.1: The facility</p> <p>The people: I feel the environment is designed in a way that is safe and is sensitive to my needs. I am able to enter, exit, and move around the environment freely and safely.</p> <p>Te Tiriti: The environment and setting are designed to be Māori-centred and culturally safe for Māori and whānau.</p> <p>As service providers: Our physical environment is safe, well maintained, tidy, and comfortable and accessible, and the people we deliver services to can move independently and freely throughout. The physical environment optimises people's sense of belonging, independence, interaction, and function.</p>	<p>PA Moderate</p>	<p>The building warrant of fitness was current to February 2024. Buildings, plant, and equipment complied with the legislation relevant to the service being provided. A whānau room has been created since the last audit allowing residents space to meet with visitors in private and partake in cultural activities. A preventative and reactive maintenance schedule was implemented. This included monthly checks of all areas and specific equipment such as hoists. The Provider has an electronic system in place to record maintenance issues, however staff were preferring to use a hard copy book to log all maintenance issues. This information was reviewed by the maintenance person and prioritised. Staff confirmed awareness of the process for maintenance requests and confirmed repairs were conducted in a timely manner. The maintenance person works in tandem with the FM to ensure hazards were identified, documented in the hazard register, and reviewed. The FM maintains responsibility for ensuring the register was current.</p> <p>Interviews with staff and visual inspection confirmed there was adequate equipment to support care. The facility had an up-to-date testing and tagging programme. There was a system in place to ensure the facility van was routinely maintained and the warrant of fitness and registration remained current. All staff who drive the van are required to have a driver's license with no previous driving convictions and a first aid</p>

		<p>certificate.</p> <p>The maintenance person confirmed that a system was in place that ensured all hot water temperatures were regularly checked and all anomalies were addressed as soon as possible. The FM was notified as required.</p> <p>All areas can be accessed with mobility aids. There were accessible external areas for residents and their visitors that provided shade and seating. There were sufficient toilet facilities available for residents and visitors however rat poison was noted to be placed in a toilet at the front of the facility. All communal toilets had a system to indicate vacancy and provided disability access. All showers, toilets, resident bedrooms and lounges had call bells however there was yet to be a call bell placed in the residents' dining room (see 4.2.5). Residents have their own rooms, and each is of sufficient size to allow residents to mobilise safely around their personal space and bed area with mobility aids and/or assistance. Observations and interviews evidenced that space for hoists, wheelchairs, and walking frames was adequate.</p> <p>All resident rooms and communal areas were ventilated with at least one external window providing natural light. Resident rooms were heated in winter and cooled in summer. This was confirmed by staff, residents, and whānau. The environment was noted to be maintained at a satisfactory temperature.</p> <p>In the event of additions to the facility Māori consultation could be accessed via established links within the community and assistance from UCG head office.</p>
<p>Subsection 4.2: Security of people and workforce</p> <p>The people: I trust that if there is an emergency, my service provider will ensure I am safe.</p> <p>Te Tiriti: Service providers provide quality information on emergency and security arrangements to Māori and whānau.</p> <p>As service providers: We deliver care and support in a planned and safe way, including during an emergency or unexpected event.</p>	<p>PA Moderate</p>	<p>There was a suite of policies and procedures related to the management of emergencies. Staff confirmed they were familiar with these and described their role in the event of an emergency. Induction of new staff included training in fire and emergency procedures however staff training records were incomplete, making compliance with this difficult to ascertain (refer 2.3.4). Fire drills and emergency evacuations were completed at least six monthly with the next one due the week after the audit. Emergency exit doors were sign posted throughout the facility.</p>

		<p>These were noted to be free from obstruction.</p> <p>The evacuation plan had been approved by Fire and Emergency New Zealand (FENZ). Fire extinguishers were strategically placed throughout the facility and had been checked within the last twelve months by a contracted service.</p> <p>Residents and whānau were advised of the facility's emergency responses on admission. Emergency procedures were explained to the audit team on arrival. Emergency flip charts and floor plans were located at prominent locations in each wing. Each shift had at least one staff member with a current first aid certificate. This was confirmed by review of staff records and staff rosters.</p> <p>Battery lighting was utilised in the event of a power failure, with multiple torches on hand to provide additional lighting. In the event of a prolonged power outage the facility had a contract with a service that ensured the facility had priority accessing a generator. The supply of water was sufficient for a minimum of three days however the provisions of food were not adequate to sustain staff and residents in the event of a civil defence emergency.</p> <p>There was a call bell in all resident's bedrooms and bathrooms. Other call bells were strategically placed throughout the facility however there was no provision of a call bell in the residents dining area. Senior afternoon duty staff were responsible for ensuring a security check of the facility occurs on dusk each evening ensuring all windows and doors are locked. Additional security measures included visitors signing in and out, staff wearing the organisations uniforms with name badges and security lighting.</p>
<p>Subsection 5.1: Governance</p> <p>The people: I trust the service provider shows competent leadership to manage my risk of infection and use antimicrobials appropriately.</p> <p>Te Tiriti: Monitoring of equity for Māori is an important component of IP and AMS programme governance.</p> <p>As service providers: Our governance is accountable for</p>	<p>FA</p>	<p>Infection prevention (IP) and antimicrobial stewardship (AMS) are an integral part of the UCG strategic plan to ensure an environment that minimises the risk of infection to residents, staff, and visitors by implementing an infection prevention programme.</p> <p>The Ultimate Care Group senior leadership team (SLT) have as part of their senior management team personnel with expertise in IP and AMS. Expertise can also be accessed from "Bug Control" who supply the UCG</p>

<p>ensuring the IP and AMS needs of our service are being met, and we participate in national and regional IP and AMS programmes and respond to relevant issues of national and regional concern.</p>		<p>with infection control resources.</p> <p>There was a documented pathway for reporting IP and AMS issues to the UCG Board. The onsite clinical team reported to the UCG clinical lead and the general manager who reported to the board. The UCG reflection report ensured that reporting occurs from governance and senior management back to site level.</p> <p>Policies and procedures were in place to manage IP. Significant IP events were managed using a stepwise approach to risk management and received the appropriate level of organisational support.</p> <p>External resources and support were available through external specialists, microbiologist, GP, wound clinical nurse specialist and Te Whatu Ora Southern when required. Overall effectiveness of the programme was monitored by the acting CSM.</p>
<p>Subsection 5.2: The infection prevention programme and implementation</p> <p>The people: I trust my provider is committed to implementing policies, systems, and processes to manage my risk of infection. Te Tiriti: The infection prevention programme is culturally safe. Communication about the programme is easy to access and navigate and messages are clear and relevant. As service providers: We develop and implement an infection prevention programme that is appropriate to the needs, size, and scope of our services.</p>	<p>FA</p>	<p>The infection prevention programme was appropriate for the size and complexity of the service. The infection prevention programme was reviewed annually and was 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 nurse (IPN) had input when IP policies and procedures are reviewed.</p> <p>An RN is the IPN. They have attended training for the role. A documented and signed role description for the IPN was sighted. The IPN reported to the acting CSM / clinical coach. The IPN was supported by the infection prevention committee which consisted of the FM and representatives from all work areas. Infection prevention reports were discussed at staff meetings. The IPN had access to all relevant resident data to undertake surveillance, internal audits, and investigations. Staff interviewed demonstrated an understanding of the infection prevention programme.</p> <p>Policies and procedures reflected current best practice relating to infection prevention and included policies for hand hygiene, aseptic technique, transmission-based precautions, prevention of sharps injuries, prevention and management of communicable infectious diseases, management of current and emerging multidrug-resistant</p>

	<p>organisms (MDRO), outbreak management, single use items, healthcare acquired infection (HAI) and the built environment. Single use medical devices were not reused. Cleaning and laundry management policies were in place.</p> <p>Infection prevention resources including personal protective equipment (PPE) were available should a resident infection or outbreak occur. There were ample reserves onsite and a system in place if additional stock is required. The FM and IPN had responsibility for purchasing equipment/resources for infection prevention in collaboration with the national office. Staff were observed to be complying with the infection prevention policies and procedures. Staff demonstrated knowledge on the requirements of standard precautions and were able to locate policies and procedures.</p> <p>The IPN was responsible for coordinating/providing education and training to staff. The orientation package included specific training around hand hygiene and standard precautions. Annual infection prevention training was included in the mandatory in-service education. Staff had completed infection prevention education in the last 12 months. The IPN had access to an online training system with resources, guidelines, and best practice. Infection control audits had been completed. There was a process to review outcomes and audit compliance. Audit outcomes were benchmarked against other UCG facilities, and this information was available to the facility staff and to the board. Compliance with the audit schedule was confirmed through review of records and benchmarking data provided.</p> <p>Infection prevention representation included input into new buildings or significant changes occurred at local and national level and involved the FM and the senior leadership team.</p> <p>The outbreak and the pandemic plans had been implemented successfully during the COVID-19 pandemic and had been reviewed and tested at regular intervals. No outbreaks had occurred since the previous onsite audit. Hand sanitisers and gels were available for staff, residents, and visitors to the facility.</p> <p>Education for residents, including those who identified as Māori, regarding infections occurred on a one-to-one basis and included advice and education about hand hygiene, medications prescribed and</p>
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		requirements for isolation. Educational resources are available in Te reo Māori.
<p>Subsection 5.3: Antimicrobial stewardship (AMS) programme and implementation</p> <p>The people: I trust that my service provider is committed to responsible antimicrobial use.</p> <p>Te Tiriti: The antimicrobial stewardship programme is culturally safe and easy to access, and messages are clear and relevant.</p> <p>As service providers: We promote responsible antimicrobials prescribing and implement an AMS programme that is appropriate to the needs, size, and scope of our services.</p>	FA	<p>An antimicrobial stewardship programme (AMS) was in place. The AMS programme was developed and implemented to optimise antimicrobial use and to minimise harm. There were approved policies and guidelines for antimicrobial prescribing.</p> <p>Infection prevention and control data was collected and analysed. Once submitted it included all surveillance data such as the infection management system and AMS surveillance outcomes alongside audits for infections. The medication management system captured surveillance data on antibiotic prescribing, allergies/sensitivities for the AMS programme. Staff outlined how cultural advice was accessed when indicated to ensure the IP programme remains culturally safe. All new staff received induction/orientation including infection prevention and this was available on-line. The IPN provided planned and opportunistic education for staff.</p> <p>Prescribing of antimicrobial use was monitored, recorded, and analysed at site level. Further discussion took place at senior management level and was reported to the board. Trends were identified both at site level and national level. Feedback occurred in the UCG reflection report and individually to the IPN if appropriate. The effectiveness of the AMS programme was continually evaluated, and any areas identified for improvement were actioned. Reporting including analysed data was included the monthly quality report through to the board. Staff were informed about antibiotic prescribing and the relationship to the increase of multi drug resistant organisms.</p>
<p>Subsection 5.4: Surveillance of health care-associated infection (HAI)</p> <p>The people: My health and progress are monitored as part of the surveillance programme.</p> <p>Te Tiriti: Surveillance is culturally safe and monitored by ethnicity.</p>	FA	<p>Surveillance was an integral part of the infection prevention and control programme. The surveillance undertaken was detailed in 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 acting CSM and the IPN used the information obtained through surveillance to determine infection</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>prevention activities, resources, and education needs.</p> <p>Monthly infection data was collected for all infections based on standard definitions. Infection prevention data was monitored and evaluated monthly and annually. This included monitoring positive results for infections and outbreaks as well as the inclusion of ethnicity data. Trends were identified and analysed, and corrective actions were established where trends were identified. These, along with outcomes and actions were discussed at staff meetings. Meeting minutes were available to all staff. Variances in trends in surveillance data was identified and investigated as verified during interview. Results of surveillance were discussed and reported to clinical governance as required.</p> <p>Residents who developed an infection were informed and family/whānau were advised. Culturally safe communication processes were outlined within the Māori health plan for residents with healthcare associated infections (HAI).</p> <p>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.</p> <p>Monthly surveillance data was collected and reported to the executive team, Trends, and opportunities to improve are considered by the acting CSM, the IPN and the national clinical lead. There were no trends identified in IP documents sampled. The reports were discussed at staff meetings, and this was verified by staff. The GP stated that residents with symptoms of infection were reviewed in a timely manner.</p>
<p>Subsection 5.5: Environment</p> <p>The people: I trust health care and support workers to maintain a hygienic environment. My feedback is sought on cleanliness within the environment.</p> <p>Te Tiriti: Māori are assured that culturally safe and appropriate decisions are made in relation to infection prevention and environment. Communication about the environment is culturally</p>	<p>PA Low</p>	<p>The facility implemented UCG waste and hazardous management policies that conformed to legislative and local council requirements. Policies included, but were not limited to, considerations of staff orientation and education; incident/accident and hazards reporting; use of PPE; disposal of general, infectious, and hazardous waste.</p> <p>Current material safety data information sheets were available and accessible to staff in relevant places, such as the laundry and the sluice</p>

<p>safe and easily accessible.</p> <p>As service providers: We deliver services in a clean, hygienic environment that facilitates the prevention of infection and transmission of antimicrobial resistant organisms.</p>		<p>room. Staff completed a chemical safety training module on orientation.</p> <p>Staff received education on waste management and infection prevention as a component of mandatory training. Yellow containers for sharps and syringes were viewed in clinical areas. The process to manage these were confirmed.</p> <p>Interviews and observations confirmed that there is sufficient PPE and equipment provided, such as aprons, gloves, and masks. Interviews confirmed that the use of PPE is appropriate to the risk. Observation confirmed that PPE was used in high-risk areas.</p> <p>Laundry and cleaning services are provided seven days a week by housekeeping staff. Rosters sampled confirmed that cleaning and laundry duties are scheduled part time each day with caregivers on afternoon and night shifts, completing any additional laundry tasks required. Visual inspection of the laundry demonstrated that there was a demarcation line between the clean and dirty areas of the laundry however it was observed that separation of clean and dirty laundry was not adhered to in practice (refer 5.5.4). Laundry personnel interviewed demonstrated knowledge of the process to handle and wash infectious items. Laundry audits were completed. Clean linen was stored appropriately in hall cupboards with linen trolleys covered when in use. Residents' clothing was labelled and personally delivered from the laundry, as observed. Residents and families/whānau confirmed satisfaction with laundry services in interviews and satisfaction surveys.</p> <p>Cleaning duties and procedures were documented to ensure correct cleaning processes occur. Cleaning products were dispensed from an in-line system according to the cleaning procedure. There were designated locked cupboards for the safe and hygienic storage of cleaning equipment and chemicals. Chemical bottles/cans in storage and in use were noted to be appropriately labelled.</p> <p>There was a policy to provide direction and guidance to safely reduce the risk of infection during construction, renovation, installation, and maintenance activities. The policy details consultation by the infection control team. There was no construction, installation, or maintenance in progress at the time of the audit.</p>
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<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>Policies, procedures, and processes were in place to guide practice related to the use of restraint. The organisation has a restraint philosophy aimed towards a restraint free environment. All restraint practice was managed through an established process consistently across all Ultimate Care Group facilities. The UCG clinical lead was responsible for restraint practices throughout UCG facilities. The acting CSM was the restraint coordinator at Rose Lodge.</p> <p>When restraint was considered, the decision-making escalation process required input from the national restraint team. Staff interviews confirmed the organisations approach to the elimination of restraint and management of behavioural challenges through alternative means. Falls risks were highlighted as part of this approach and outcomes considered along with other alternatives. The safety of residents and staff was always considered by the restraint team, and this was discussed.</p> <p>Records confirmed the completion of restraint minimisation and safe restraint use training with annual updates completed. Staff reported they were trained and competent to manage challenging behaviour, documentation confirmed this.</p> <p>Staff interviewed confirmed the processes that were required for Māori residents when considering restraint or if restraint practice was implemented. Discussion included staff commitment to ensuring the voice of people with lived experience, there were processes in place to ensure Māori/whānau oversight is provided.</p> <p>Executive leaders received restraint reports monthly alongside aggregated restraint data, including the type and frequency of restraint if restraint had occurred. This formed part of the regular reflection report to the board.</p> <p>There were no episodes of restraint recorded since the last audit. Restraint was only considered a last resort.</p>
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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 2.2.3</p> <p>Service providers shall evaluate progress against quality outcomes.</p>	<p>PA</p> <p>Moderate</p>	<p>Review of meeting minutes and discussion with staff evidenced that meeting minutes were inconsistently completed. Meeting minutes had information missing including names of people attending, the date the meeting was held, what was discussed, who had been allocated tasks to address the issue, timeframes of completion and what had been put in place in order for the issue to be closed. Information was missing that evidenced staff were informed of the outcomes.</p>	<p>Meeting minutes provided insufficient information that quality outcomes were communicated.</p>	<p>Ensure the UCG meeting process is consistently followed, and all documentation is complete including date of the meeting, attendees, items discussed, who is responsible for tasks allocated to address the issue raised, timeframes for this to be completed, and what was improved for the issue to be closed. Ensure all staff and/or residents involved are updated regarding the outcome.</p> <p>180 days</p>
<p>Criterion 2.3.4</p> <p>Service providers shall ensure there is a system to identify, plan, facilitate, and record</p>	<p>PA</p> <p>Low</p>	<p>Review of staff training records and discussion with staff evidenced that there is yet to be a system implemented that accurately captures</p>	<p>Current staff training records do not record all staff training attended and when the</p>	<p>Ensure a system is implemented that records all staff training attended and ongoing development.</p>

ongoing learning and development for health care and support workers so that they can provide high-quality safe services.		staff attendance for training and when the next training is due.	next training is due.	180 days
Criterion 2.4.5 Health care and support workers shall have the opportunity to discuss and review performance at defined intervals.	PA Low	Staff records sampled evidenced that annual appraisals had been carried out for staff employed 12 months or more. However annual appraisals for some clinical staff had been completed by the non-clinical FM with no clinical oversight by a senior clinical manager.	Performance appraisals for clinical staff, did not have input from a senior clinical staff member.	Ensure all clinical staff have their appraisals completed by suitably trained senior clinical staff. 180 days
Criterion 2.4.6 Information held about health care and support workers shall be accurate, relevant, secure, and confidential. Ethnicity data shall be collected, recorded, and used in accordance with Health Information Standards Organisation (HISO) requirements.	PA Low	Staff records sampled had information missing and were insecure. For example, some employee's information pertaining to their referee checks had been left unfiled on an office desk.	Staff records were insecure leaving personal information accessible for non-authorized personnel.	Ensure all staff records are maintained in one file and confidentiality is maintained for all staff information. 180 days
Criterion 2.5.2 Service providers shall maintain an information management system that: (a) Ensures the captured data is collected and stored through a centralised system to reduce multiple copies or versions, inconsistencies, and duplication; (b) Makes the information	PA Low	Review of resident records and discussion with staff evidenced that resident's medical information was being entered into two different systems. Staff were not always aware of all information and some updates were not communicated.	Residents' medical records were not integrated.	Ensure all residents medical records are integrated 180 days

manageable; (c) Ensures the information is accessible for all those who need it; (d) Complies with relevant legislation; (e) Integrates an individual's health and support records.				
Criterion 4.1.2 The physical environment, internal and external, shall be safe and accessible, minimise risk of harm, and promote safe mobility and independence.	PA Moderate	During the walk around the facility, it was noted that rat poison had been placed on the floor in the staff toilet at the front entrance to the building. This door had keypad access however it was noted to be left open at times during the audit.	Rat poison had been left in a toilet at the front of the facility creating a significant hazard.	Remove rat poison from the toilet and ensure safer options are put in place to manage vermin issues. 30 days
Criterion 4.2.5 An appropriate call system shall be available to summon assistance when required.	PA Moderate	Observation on day one of audit and discussion with staff evidenced there was no call bell in the resident's dining room.	Staff were unable to summons help for residents in the dining room as there was no call bell in place.	Ensure a call bell is placed in the dining room that is in line with the current call system in place in the facility. 90 days
Criterion 4.2.7 Alternative essential energy and utility sources shall be available, in the event of the main supplies failing.	PA Moderate	Observation and discussion with staff evidenced there was inadequate supplies of food items to sustain residents and staff in the event of a civil defence emergency.	Supplies for residents and staff were inadequate to sustain everyone for three days in the event of a civil defence emergency occurring.	Ensure supplies of food are adequate to sustain all resident's and staff for three days in the event of a civil defence emergency. 30 days
Criterion 5.5.4 Service providers shall ensure	PA Low	There was a clear demarcation line between the clean and dirty areas of	Clean linen was being handled and processed	Ensure there is clear separation between handling and processing of

<p>there are safe and effective laundry services appropriate to the size and scope of the health and disability service that include:</p> <ul style="list-style-type: none"> (a) Methods, frequency, and materials used for laundry processes; (b) Laundry processes being monitored for effectiveness; (c) A clear separation between handling and storage of clean and dirty laundry; (d) Access to designated areas for the safe and hygienic storage of laundry equipment and chemicals. This shall be reflected in a written policy. 		<p>the laundry, however, a laundry dryer was being used in the dirty side of the laundry.</p>	<p>in the designated dirty side of the laundry.</p>	<p>clean and dirty laundry.</p> <p>180 days</p>
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.