The Ultimate Care Group Limited - Ultimate Care Kensington Court

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 Kensington Court
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 18 March 2024 End date: 19 March 2024

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: 60

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

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

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All subsections applicable to this service fully are 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 Kensington Court is part of the Ultimate Care Limited Group. It is certified to provide care for up to 81 residents requiring hospital or rest home level care. The facility manager has recently been made permanent in the role having been leading the facility in an acting capacity. The clinical services manager takes overall responsibility of all matters clinical and has been in the role since September 2023. Additionally, the organisation has recently appointed a national clinical lead within its clinical governance team.

This certification audit was conducted against the Ngā Paerewa Health and Disability services standard NZS8134:2021 and the provider contracts with Health New Zealand Te Whatu Ora – Nelson Marlborough. The audit process included review of policies and procedures, review of resident and staff records, observations, and interviews with residents, whānau, a general practitioner, and the regional manager who provided support for the team during this audit. Observations were made throughout the audit including the medication round, meal service, laundry services and the activities programme.

An area identified as requiring improvement related to emergency 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.

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

Staff received training in Te Tiriti o Waitangi and cultural safety that was reflected in service delivery. Care was provided 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.		Subsections applicable to this service are fully attained.

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 provider has undergone several changes within the management team since the last audit. The facility manager was supported by the clinical services manager. The regional manager provides support via weekly online meetings and regular face to face and has provided additional support as the facility manager settles in and during the ongoing changes within the management team.

Quality and risk 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. There was 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.

The model of care provided ensured wholistic resident centred care was provided. Information was provided to potential residents and whānau prior to admission to inform decision making.

Resident assessments informed care plan development. Care plans were implemented with input from the resident and whānau and contributed to achieving the resident's goals. Review of the care plans occurred regularly. Interventions reflected best practice. Other health and disability services were engaged to support the resident as required. The activity programme supported residents to maintain physical, social, and mental health aspirations.

Medicine management reflected best practice, and staff who administered medication were competent to do so. The discharge and/or transfer of residents was safely managed. The general practitioner stated the provision of care met the resident's needs.

Te aro ki te tangata me te taiao haumaru | 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.

The organisation maintains an appropriate environment. A reactive and preventative maintenance programme was implemented. External areas provided safe seating and shade for residents who could walk freely around the gardens.

Resident rooms were of an appropriate size and allowed for personal memorabilia and additional furniture. Lounge and dining areas provided spaces for residents and their visitors. Communal and individual spaces were maintained at a comfortable temperature.

A call bell system allowed residents and staff to access help when required. Security systems were in place and staff were trained in emergency procedures and use of equipment/supplies. A system was in place that ensured power supplies would be maintained should the main supply fail at any time.

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

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

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

The organisation supported the safety of residents and staff via the infection prevention and antimicrobial stewardship programmes. The programmes were appropriate for the size, complexity, and type of service. The clinical services manager was responsible for the implementation of the programmes. The infectious diseases/pandemic plan had been tested. Staff were educated in the principles of infection control. A surveillance programme was implemented that enabled the analysis and detection of trends. Cleaning and laundry processes were implemented in line with best practice infection prevention and waste management guidelines.

Here taratahi | Restraint and seclusion

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

Restraint minimisation and safe practice policies and procedures were in place. Ultimate Care Group Limited maintain a clear stance that all facilities only use restraint as a last resort with an overall aim that they remain restraint free. The facility was maintaining that stance and on day of audit there were no residents using a restraint. Restraint minimisation was overseen by the restraint coordinator.

Staff had completed restraint elimination and safe practice training. Information related to restraint was made available at executive 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	26	0	0	1	0	0
Criteria	0	168	0	0	1	0	0

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

Attainment against the Ngā paerewa Health and disability services standard

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

For more information on the standard, please click here.

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

Subsection with desired outcome	Attainment Rating	Audit Evidence
Subsection 1.1: Pae ora healthy futures Te Tiriti: Māori flourish and thrive in an environment that enables good health and wellbeing. As service providers: We work collaboratively to embrace, support, and encourage a Māori worldview of health and provide high-quality, equitable, and effective services for Māori framed by Te Tiriti o Waitangi.	FA	Staff 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. Training records sampled evidenced that all staff had completed this except for new staff who were completing an orientation programme. 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. The regional manager (RM) who provided support for the newly appointed facility manager (FM) outlined how this was implemented. The plan describes the aims of UCG to ensure outcomes for Māori are equitable. Strategies include but are not limited to, identifying priority areas for leadership to focus upon, and increase the knowledge base across the organisation underpinned by Mātauranga Māori. The document outlines the importance of ensuring any resident that identifies as Māori would have the opportunity to have whānau involved in their care. The RM outlined the formal links that were established with the facility

		and the local Māori community. There were residents who identified as Māori residing in the facility on day of audit.
Subsection 1.2: Ola manuia of Pacific peoples in Aotearoa The people: Pacific peoples in Aotearoa are entitled to live and enjoy good health and wellbeing. Te Tiriti: Pacific peoples acknowledge the mana whenua of Aotearoa as tuakana and commit to supporting them to achieve tino rangatiratanga. As service providers: We provide comprehensive and equitable health and disability services underpinned by Pacific worldviews and developed in collaboration with Pacific peoples for improved health outcomes.	FA	The Pacific plan outlines the organisations commitment to providing culturally safe care. It defines and explains 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 RM outlined what Pacific community connections were in place within the Nelson community. The organisation has developed a strategy that ensures a Pacific health and wellbeing workforce was recruited and retained across the organisation. The RM outlined how this was implemented and what community connections were in place and the benefits of these partnerships.
Subsection 1.3: My rights during service delivery The People: My rights have meaningful effect through the actions and behaviours of others. Te Tiriti:Service providers recognise Māori mana motuhake (self-determination). As service providers: We provide services and support to people in a way that upholds their rights and complies with legal requirements.	FA	The Code of Health and Disability Services Consumers' Rights (the Code) was on display throughout the facility written in English and te reo Māori. 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 care was provided in accordance with the Code. Staff records sampled evidenced that training regarding the Code formed part of the orientation schedule. Staff interview and review of admission packs confirmed that information regarding the Code was included in all packs with further explanation given by staff in regards what this means in relation to care delivery. Further discussion with staff and whānau interviews confirmed that residents, whānau and/or the enduring power of attorney (EPoA) had been consulted and involved in discussions regarding care and residents' rights. Staff outlined that they were aware of the advocacy service and gave

		examples of when this support would be beneficial. The FM outlined the provider has ensured that staff and residents are aware of the national advocacy service and how to contact the service. Policy and practice include ensuring that all residents, including any Māori residents right to self-determination is upheld and they can practice their own beliefs and values. The Māori health action plan identifies how UCG responds to Māori cultural needs in relation to health and illness.
Subsection 1.4: I am treated with respect The People: I can be who I am when I am treated with dignity and respect. Te Tiriti: Service providers commit to Māori mana motuhake. As service providers: We provide services and support to people in a way that is inclusive and respects their identity and their experiences.	FA	The provider ensured that residents and whānau/EPoA were involved in planning and care which was inclusive of discussions and choices regarding maintaining their 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. 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. Staff, resident and whānau interviews plus observation confirmed that staff knock on doors before entering, address residents using their preferred name and maintain confidentiality when holding conversations that were personal in nature. Staff receive training in Te Tiriti o Waitangi and tikanga best practice and have additional resources available to provide ongoing guidance. The FM takes responsibility for monitoring staff compliance with this. Staff were encouraged to learn and use basic greetings in te reo Māori. Signage throughout the facility was in te reo Māori and English. The organisation supports tāngata whaikaha to do well with documentation outlining how staff work in partnership with residents to ensure strengths and abilities are maintained. Evidence of how this was achieved was visible within resident records sampled.
Subsection 1.5: I am protected from abuse	FA	There was policy that included definitions, guidelines, and

The People: I feel safe and protected from abuse. Te Tiriti: Service providers provide culturally and clinically safe services for Māori, so they feel safe and are protected from abuse. As service providers: We ensure the people using our services are safe and protected from abuse.		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 incidents of suspected abuse. Staff and whānau confirmed there was no evidence of abuse or neglect. The admission agreement provides clear expectations regarding management responsibilities of personal property and finances. Resident agreements sampled had all been signed with consent documented for the administrator to manage residents comfort funds. Discussion with the administrator and review of systems implemented evidenced that residents comfort funds are managed safely and accurately. Resident and whānau interviews outlined that staff respect resident's property and that they were satisfied with all aspects of the comfort fund management. 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. 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 respective roles. Whānau interviewed confirmed that professional boundaries were maintained. Whānau interviewed described how they feel confident their relative was in safe hands and were complimentary regarding the level of care. Whānau provided further evidence that they felt comfortable to raise any concerns and discussions were free and open. The Māori health plan promotes a strengths based and holistic model of care for Māori. Resident files sampled confirmed that care was provided using a holistic model and resident's strengths were focused on.
Subsection 1.6: Effective communication occurs	FA	There was policy to ensure that residents and their whānau have the

The people: I feel listened to and that what I say is valued, and I feel that all information exchanged contributes to enhancing my wellbeing. Te Tiriti: Services are easy to access and navigate and give clear and relevant health messages to Māori. As service providers: We listen and respect the voices of the people who use our services and effectively communicate with them about their choices.		right to comprehensive information supplied in a way that was appropriate and considered specific language requirements and disabilities. The RM confirmed that if required interpreters could be accessed from Health New Zealand - Te Whatu Ora Nelson Marlborough. Resident records sampled evidenced that other health agencies were involved in resident care providing additional assessments and treatment regimens as required. There was policy which required whānau to be advised within 24 hours of an adverse event occurring. Review of accident/incident information and staff and whānau interviews confirmed that timeframes were met, and open disclosure had occurred following an event involving a resident. Two monthly resident meetings were scheduled, and review of documentation and staff interview evidenced that these had occurred as planned. High numbers of whānau had attended with a small but appropriate number of items raised for discussion outlined within the meeting minutes. Whānau interviewed stated they found the meetings helpful to ensure they found out what was happening within the facility especially as there has been changes within the management team over the last eighteen months. Meetings were advertised in the activities planner with reminders of what was coming up placed on noticeboards. Copies of the menu and activities plan were made available to residents and whānau.
Subsection 1.7: I am informed and able to make choices The people: I know I will be asked for my views. My choices will be respected when making decisions about my wellbeing. If my choices cannot be upheld, I will be provided with information that supports me to understand why. Te Tiriti: High-quality services are provided that are easy to access and navigate. Providers give clear and relevant messages so that individuals and whānau can effectively manage their own health, keep well, and live well.	FA	The informed consent policy was in line with the Code and included the process to be followed for advanced directives. The policy outlined how staff were to ensure residents and/or their whānau were to be given time and appropriate information to enable informed consent for all aspects of care. Resident records sampled included signed consent for photographs, collection and storage of information and outings. All resident records sampled had the resident's resuscitation status documented and signed by the general practitioner (GP). Staff interviewed were able to outline tikanga guidelines and that this

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.		had been a component of their orientation and ongoing in-service education. Whānau interviewed confirmed they were given sufficient information and timeframes to make decisions appropriate to their relatives' care.
Subsection 1.8: I have the right to complain The people: I feel it is easy to make a complaint. When I complain I am taken seriously and receive a timely response. Te Tiriti: Māori and whānau are at the centre of the health and disability system, as active partners in improving the system and their care and support. As service providers: We have a fair, transparent, and equitable system in place to easily receive and resolve or escalate complaints in a manner that leads to quality improvement.	FA	The organisation had a complaints process that aligned with consumer rights legislation. The process was confirmed to be transparent and equitable and formed part of the admission information given to all residents and/or whānau. Complaint forms were easily accessed within the facility with reminders about the process available in poster form throughout the facility. Residents and whānau confirmed they were aware of the process to make a complaint and acknowledged they were encouraged to give feedback. The FM confirmed that support was readily available for Māori residents/whānau to navigate the complaints process. All complaints received were lodged on the electronic system. The complaints register was reviewed. All complaints lodged had been managed in accordance with UCG policy and procedure. Evidence was provided that the complainants had been informed of the outcome and all complaints had been closed. It was reported there were no complaints lodged with external agencies at time of audit.
Subsection 2.1: Governance The people: I trust the people governing the service to have the knowledge, integrity, and ability to empower the communities they serve. Te Tiriti: Honouring Te Tiriti, Māori participate in governance in partnership, experiencing meaningful inclusion on all governance bodies and having substantive input into organisational operational policies. As service providers: Our governance body is accountable for delivering a highquality service that is responsive, inclusive, and	FA	Ultimate Care Kensington Court is part of Ultimate Care Group 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 that enacts the principles of Te Tiriti o Waitangi. It has been reported that the organisation continues to focus upon its obligations under Te Tiriti o Waitangi and cultural safety, The governance structure has had a recent change with the commencement of a new national clinical lead. An executive team provides direction to the provider. The annual strategic business plan has key outcomes which are resident

sensitive to the cultural diversity of communities we serve.		centred, such as health and safety, complaints, education, and fiscal stability. There were monitored at board meetings. The organisation has a documented strategy plan incorporating their 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 the information available to residents and whānau. The Māori health action plan describes how the organisation was aware of barriers and inequities for Māori and how to reduce them. Staff were encouraged to learn and use basic Māori greetings and upskill in Māori tikanga. Whānau were encouraged to have input into service improvement as confirmed by staff and whānau. The UCG management team have seven clinical coaches across the organisation to provide clinical support and mentorship. The clinical services manager (CSM) confirmed this support was valued. The clinical coaches ensure key indicators were disseminated to the national clinical lead. The new FM has a background in village management and administration. The RM has been providing support to the facility whilst the FM was settling into the role and provided support for this audit. The FM reports to the RM who has weekly online meetings with all managers in the allocated region with regular face to face contact. The CSM has a varied clinical background and has been in the role since September 2023. The organisation has implemented robust systems to support 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. The Māori health action plan outlines the organisations commitment to improving outcomes for tāngata whaikaha. This includes the support required to achieve aspirations and reduce barriers. The organisation continues to focus upon the need to prioritise the building of relationships with Māori disability stakeholders. The provider is certified to provide rest home and hospital level care for

		up to 81 residents. Beds comprise of 24 rest home, 16 hospital level, 15 dual purpose beds. Plus 24 rest home level studios/apartments and 2 dual purpose care suites. On the first day of audit there were a total of 60 residents, 16 receiving hospital level care and 44 receiving rest home level care. Included in these numbers were five residents in apartments with occupational rights agreements (ORAs), assessed as requiring rest home level care. The provider has contracts with Health New Zealand Te Whatu Ora – Nelson Marlborough for aged related residential care, chronic health conditions, end of life and support care medical illness.
Subsection 2.2: Quality and risk The people: I trust there are systems in place that keep me safe, are responsive, and are focused on improving my experience and outcomes of care. Te Tiriti: Service providers allocate appropriate resources to specifically address continuous quality improvement with a focus on achieving Māori health equity. As service providers: We have effective and organisation-wide governance systems in place relating to continuous quality improvement that take a risk-based approach, and these systems meet the needs of people using the services and our health care and support workers.	FA	The 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 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. The 2023 UCG Kensington Court annual residents/relatives survey results for 2023 were reviewed with many areas surveyed producing results of 90% and above satisfaction rates. There was an implemented annual schedule of internal audits. Areas of non-compliance including the implementation of a corrective action plan was the responsibility of the FM or CSM dependent upon the issue being operational or clinical. A reporting tool captures a broad range of information across all facilities. The CSM took responsibility for health and safety for the facility and had a signed job description for the role. The provider has made a commitment to ensuring all staff were aware of the importance of health and safety with an ongoing focus on minimising accidents or incidents. The provider had a set schedule of meetings in place including quality, health and safety, staff, residents/whānau. Meeting minutes outlined who attended, what was discussed, who was taking responsibility for follow up and when the issue was closed.

		The organisation follows the UCG adverse event reporting policy for internal and external reporting. The RM confirmed that a section 31 was completed for the appointment of the FM and CSM and expressed an understanding of what other events constituted the need for section 31 completion. 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 improvement plans created when progress was less than optimal.
Subsection 2.3: Service management The people: Skilled, caring health care and support workers listen to me, provide personalised care, and treat me as a whole person. Te Tiriti: The delivery of high-quality health care that is culturally responsive to the needs and aspirations of Māori is achieved through the use of health equity and quality improvement tools. As service providers: We ensure our day-to-day operation is managed to deliver effective person-centred and whānau-centred services.	FA	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. Review of the providers staff training schedule, review of staff records and interviews evidenced that employees have the appropriate qualifications to fulfil their roles. The FM works 40 hours per week and provides after hours support for operational issues. The CSM works 40 hours per week and provides additional support should the rostered-on call RN require this. The morning shift comprises of one RN and seven care givers, the afternoon shift comprises of one RN and six care givers, and night shift has one RN and three care givers. Following a successful recruitment campaign the previous RN short fall has been addressed with three shifts per week currently without an RN on duty. Shift leads cover these absences who are all senior care givers who have current medication competency, a current first aid certificates and had completed additional UCG training in STOP and WATCH acute deterioration assessment training. This includes the guidelines to follow to ensure the escalation pathway is followed for residents of concern. The RM advised that a section 31 notification is completed weekly whist these shifts have no RN rostered. Nonclinical staff included cleaning, laundry, kitchen and maintenance personnel. The activities programme

		ran five days per week managed by the diversional therapist (DT) and an activities coordinator. Laundry and cleaning staff were rostered part time across the week. Interviews with residents, whānau, and staff advised staffing levels have improved over recent times and they were not aware of any staffing issues impacting on residents or service delivery. There was an implemented training programme. Staff competencies, training and education scheduled were relevant to the needs of the residents. Staff attendances for training delivered over the last twelve months was reviewed with an improvement noted over recent months since the FM has been appointed. A focus plan has been implemented to ensure all staff training was up to date with the FM taking responsibility to follow up staff who were yet to complete overdue training. The current cultural safety training schedule provides staff with resources to support their practice to achieve equitable health outcomes. The CSM has completed interRAI training. 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 an improved work environment was confirmed by staff after the many changes in management over the last 18 months. Employee support services were available when required.
Subsection 2.4: Health care and support workers The people: People providing my support have knowledge, skills, values, and attitudes that align with my needs. A diverse mix of people in adequate numbers meet my needs. Te Tiriti: Service providers actively recruit and retain a Māori health workforce and invest in building and maintaining their capacity and capability to deliver health care that meets the needs of Māori. As service providers: We have sufficient health care and support workers who are skilled and qualified to provide clinically and culturally safe, respectful, quality care and services.	FA	The organisations human resource systems and policies outline the principles of good employment practice and the Employment Relations Act 2000. Staff records sampled evidenced that policy and procedure had been consistently followed. The recruitment process includes police vetting, reference checks, and validation of annual practising certificates/qualifications. Current practising certificates were sighted for those staff and contractors that required these. The CSM was responsible for ensuring annual compliance. Job descriptions include accountabilities/responsibilities specific to the role with clear outline of who they report to. Personnel involved in driving the van used for resident outings held driver's licences without any driving convictions and first aid certificates. There was a documented and implemented orientation programme and

		staff records evidenced orientation was completed. Orientation covered the essential components of service delivery with specifics relating to their individual roles included. Staff confirmed completing this. Should the provider ever need to utilise agency nursing staff there was separate policy and plan for their orientation if required. Annual performance reviews were current and three-monthly reviews had been completed for newly appointed staff. Staff records sampled evidenced information held was accurate, relevant, secure and confidentiality was maintained. Staff interview and review of documentation evidenced that staff ethnicity data was collected, and a review of staff records provided additional information this was in place. The RM confirmed that a debrief process could be put in place when required.
Subsection 2.5: Information The people: Service providers manage my information sensitively and in accordance with my wishes. Te Tiriti: Service providers collect, store, and use quality ethnicity data in order to achieve Māori health equity. As service provider: We ensure the collection, storage, and use of personal and health information of people using our services is accurate, sufficient, secure, accessible, and confidential.	FA	Resident's records and medication charts were managed electronically. Resident information including progress notes were entered into residents' records in an accurate and timely manner. The name and designation of the author was identifiable. Residents' notes were completed every shift. There were policies and procedures in place to ensure the privacy and confidentiality of resident information. Staff confirmed their awareness of their obligation to maintain confidentiality of all resident information. Resident care and support information can be accessed appropriately and was protected from unauthorised access. Records include information obtained on admission and information supplied from a resident's whānau/EPoA. Other information including assessments and reports from other health professionals were included within the resident records. 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 requiring the national health index (NHI).

Subsection 3.1: Entry and declining entry The people: Service providers clearly communicate access, timeframes, and costs of accessing services, so that I can choose the most appropriate service provider to meet my needs. Te Tiriti: Service providers work proactively to eliminate inequities between Māori and non-Māori by ensuring fair access to quality care. As service providers: When people enter our service, we adopt a person-centred and whānau-centred approach to their care. We focus on their needs and goals and encourage input from whānau. Where we are unable to meet these needs, adequate information about the reasons for this decision is documented and communicated to the person and whānau.	FA	Information about the service was available in printed format from the facility reception, and from the Ultimate Care website. The Needs Assessment Service Coordination agency (NASC) also held information about the services provided. A documented policy outlined the entry process. The clinical services manager and facility manager worked in collaboration to co-ordinate the entry process with the resident and whānau. Residents admitted to the service required a NASC assessment and referral prior to admission. Confirmation of this process was confirmed in all clinical records sampled. A policy detailed the management for declining a potential resident and documented that a person was not declined unless the care requirements were outside the scope of the service, or no bed was available. If no bed was available, a resident enquiry form was kept. This held relevant information, including the potential resident's ethnicity. The service offered the potential resident a bed when one became available. Potential residents and their whānau were kept updated regarding bed availability by the clinical services manager or facility manager. The enquiry record is analysed and reported on at monthly executive meetings. Whānau confirmed this process occurred, and that the admission process was straightforward and respectful. Residents expressed satisfaction with the admission process and confirmed they were treated with dignity and respect. The Māori health plan described the organisation's commitment to improving outcomes for Māori. Kensington Court had a relationship with local Māori, including kaumātua that facilitated the objective of improving health benefits for Māori.
Subsection 3.2: My pathway to wellbeing The people: I work together with my service providers so they know what matters to me, and we can decide what best supports my wellbeing. Te Tiriti: Service providers work in partnership with Māori and whānau, and support their aspirations, mana motuhake, and	FA	Residents had individualised support provided that met their physical, cultural, spiritual, and social dimensions of their wellbeing. The documented assessments demonstrated that the resident's holistic wellbeing was considered and included, for example skin integrity, pain, falls risk, sleep patterns and behaviour. All interRAI assessments and resultant long-term care plans were current at the time of the audit.

whānau rangatiratanga. As service providers: We work in partnership with people and whānau to support wellbeing.		Electronic clinical records verified that a registered nurse had completed the assessments and developed an individualised care-plan for all residents. All interRAI reviews were current in the files sampled. Care-plans documented interventions to maintain and improve the residents' health and wellbeing as reflected in the interRAI report. Progress notes, observations during the audit and interview with the resident's and their whānau confirmed that assessments and care-plans had been developed in collaboration with them. Short term care plans were developed for acute conditions for example an infection. These were updated as appropriate and signed off when the condition had resolved. Wound care plans sampled confirmed that they were assessed in a timely manner and reviewed at appropriate intervals. Photos of wound healing had been taken and uploaded into the record at each dressing change. Clinical records were integrated including, for example, correspondence from community health providers, interRAI reports, the admission agreement, consent forms and a copy of the enduring power of attorney (EPoA). A physiotherapist attended the service regularly and assessed new residents, reviewed residents six monthly, and/or on the request of nursing staff when a change in the resident's mobility had been observed. Progress notes documented the resident's daily activities and any observed changes in health status or behaviour. The clinical services manager, registered nurse and staff stated that changes in a resident's behaviour were considered an early warning sign of a residents change in health status. Monthly vital signs and the weight of residents were documented. Where progress was different to that expected, or the resident had displayed signs or symptoms of illness, vital signs were documented, and further assessments were performed as appropriate. A registered nurse developed a short-term care-plan, and the general practitioner (GP) was notified in a timely manner. This was confirmed in interview with the GP. Medical oversight of the residents was provided by a GP. The GP visited weekly, or more often if required, upon the request of the clinical services manager. The GP confirmed that residents were seen and assessed at least every three months. If the resident's condition changed between times the

		clinical services manager notified the GP and a medical review was provided. The GP also advised that residents were often seen more frequently than three months, and this enabled early diagnosis and treatment of health issues. A shift handover was observed and included the resident's medical condition/s, cares required, and a summary of any recent changes in the resident's health care needs or status. Oncoming staff were given the opportunity to clarify any aspects of the resident's care needs. There were two Māori residents living in Kensington Court at the time of the audit. The records of both residents were sampled. Both included a Māori health plan that reflected te whare tapa whā model of care. The regional manager advised that the UCG had engaged with Māori and tāngata whaikaha to support service development. Residents and family/whānau confirmed that they were included in the development of care plans, and their values, beliefs and cultural needs were respected. There was a suitable supply of medical and continence products on site during the audit.
Subsection 3.3: Individualised activities The people: I participate in what matters to me in a way that I like. Te Tiriti: Service providers support Māori community initiatives and activities that promote whanaungatanga. As service providers: We support the people using our services to maintain and develop their interests and participate in meaningful community and social activities, planned and unplanned, which are suitable for their age and stage and are satisfying to them.	FA	The activities programme was implemented by a diversional therapist and an activities assistant. Both staff were employed full-time. The programme was available to residents 0930 to 1530 hours. There was a programme on display through out the facility for both hospital and rest-home residents. The activities assistant discussed the programme, which included a wide range of activities suitable for all residents. The programme promoted physical, social, cultural and intellectual skills. Outings to the community occurred regularly for afternoon teas, scenic drives and meeting with other local rest-home residents for joint activities. Community cultural celebrations and events were included in the programme as available. Implementation of the programme was observed during the audit and residents were seen to be engaged and having fun. Clinical records sampled confirmed that assessments of the resident's life skills and experiences were considered in the development of the activities care-plan. Whānau had been engaged in the assessment and

		planning of the activities care plan verified by residents and whānau, who also stated satisfaction with the programme and stated it enhanced their well-being. Māori celebrations and activities were woven into the programme for example te reo Māori word quizzes and making a korowai with paper feathers. Whānau took family into the community to attend additional cultural activities and events as desired.
Subsection 3.4: My medication The people: I receive my medication and blood products in a safe and timely manner. Te Tiriti: Service providers shall support and advocate for Māori to access appropriate medication and blood products. As service providers: We ensure people receive their medication and blood products in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	The medication management system reflected current recommended best practice. An electronic programme was used for the prescribing and recording of the administration of medication. Medications were dispensed by a pharmacy using a pre-packaged system. The pharmacy was responsible for delivering and disposing of unwanted medications as required. A medication competent staff member checked the medications prior to them being placed in medication trolleys. Medication administration was performed by registered nurses and/or medication competent health care assistants. The medication competency programme was completed annually and included a theoretical component and observation of administration to ensure safe practice and compliance with the policy. A medication round was observed, and staff demonstrated competency administrating medication. Eye drops, ointments and creams had a documented opening date. During the audit no medications were observed to be out of date. All medication prescriptions were completed as per regulations, including the documentation of allergies and sensitivities. The GP had reviewed the medication chart every three months or more frequently as required. Standing orders were not used in this service. Over the counter medications (OTC) were discussed with the resident and family by the GP. OTC medications prescribed were administered by staff. This was confirmed by observation and in medication records sampled. There were two medication trolleys. One was for the hospital residents and the second was for rest-home residents. Both trolleys were locked and stored in a locked medication room. Controlled medications were

		stored appropriately and documentation of these reflected legislative requirements. The medication room and fridge were temperature monitored. Stock medications were sighted and included medications for the hospital residents, that may be prescribed by the GP, which were unable to be dispensed and delivered to the service within an appropriate timeframe, for example antibiotics. There was a process to ensure that self-administration of medication occurred in a safe manner. There was one resident self-administering medication during the audit. The resident's clinical record verified that a medication competency assessment had been completed and that the GP supported the residents wish to self-administer. The storage of the medication being self-medicated was appropriate. Residents were supported to understand and their medications, and this was confirmed by residents and their whānau. Medication incidents were reviewed by the clinical services manager and managed as per policy. The GP stated that the medication system and processes were safe and appropriate to the service.
Subsection 3.5: Nutrition to support wellbeing The people: Service providers meet my nutritional needs and consider my food preferences. Te Tiriti: Menu development respects and supports cultural beliefs, values, and protocols around food and access to traditional foods. As service providers: We ensure people's nutrition and hydration needs are met to promote and maintain their health and wellbeing.	FA	A nutritional assessment was undertaken by the CSM 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 these changed. 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. All meals were prepared onsite and serviced in the dining rooms or in the residents' rooms. The temperature of food served was recorded. Residents were observed to be given sufficient time to eat their meals and assistance provided when required. Residents and whānau reported a mixed response to the satisfaction with meals provided. 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 Dietitian. The food control plan expiry date was June 2024.

		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 freezers were 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. Discussion and feedback on the menu and food provided was sought individually by the cook and at the residents' meetings. For Māori residents' information was gathered regarding nutritional needs and preferences during the initial assessment and during the development of their individual Māori health plan. The cook confirmed that all residents could request culturally specific food and any request would be accommodated. Residents were able to be involved in meal preparation with an example given how a current resident was able to utilise the kitchen facilities to prepare their own baking.
Subsection 3.6: Transition, transfer, and discharge The people: I work together with my service provider so they know what matters to me, and we can decide what best supports my wellbeing when I leave the service. Te Tiriti: Service providers advocate for Māori to ensure they and whānau receive the necessary support during their transition, transfer, and discharge. As service providers: We ensure the people using our service experience consistency and continuity when leaving our services. We work alongside each person and whānau to provide and coordinate a supported transition of care or support.	FA	The transfer and discharge policy provided clear details regarding the transfer and discharge of residents in a safe and timely manner. The clinical services manager described the policy. Where a residents health status and care requirements were observed to be changing an InterRAI assessment was completed. The residents ongoing care requirements were discussed with the GP and whānau. The interRAI assessment was provided to the NASC service who updated the residents level of care requirements as required. Rest-home residents who became hospital residents continued to receive care in the same room if possible. If a resident's care requirements became outside the scope of Kensington Court, for example dementia care, the whānau were responsible for finding an alternative provider. The Kensington Court clinical services manager and facility manager supported the whānau in the process. Acute transfers to the public hospital occurred when there was a sudden change in a resident's health status and the registered nurse and/or GP

		determined the resident required specialised care. The national 'yellow envelope' system was used. In the envelope was included a hospital transfer letter which was generated by the electronic clinical record system. The letter included all relevant information and the last three entries of the progress notes. The resident's medication record was also printed and included in the envelope. Family confirmed they were notified of the resident's need to transfer to the hospital. Residents and whānau were provided information about other health and disability services when indicated or requested. This was confirmed by whānau. The clinical services manager and facility manager advised that information would be provided about kaupapa Māori agencies if required.
Subsection 4.1: The facility The people: I feel the environment is designed in a way that is safe and is sensitive to my needs. I am able to enter, exit, and move around the environment freely and safely. Te Tiriti: The environment and setting are designed to be Māori-centred and culturally safe for Māori and whānau. As service providers: Our physical environment is safe, well maintained, tidy, and comfortable and accessible, and the people we deliver services to can move independently and freely throughout. The physical environment optimises people's sense of belonging, independence, interaction, and function.	FA	The building warrant of fitness was noted to have expired however information was supplied that provided evidence of an extension being given whilst remedial work was being completed to the facility. The outstanding work posed no risk to the residents or staff. Plant and equipment complied with the legislation relevant to the service provided. A preventative and reactive maintenance schedule was implemented. The provider had an electronic system in place to record all maintenance issues. The maintenance person outlined that they followed a routine schedule that included hot water temperature checks and frequent review of the call bell system. The maintenance person worked in tandem with the FM to ensure anomalies were addressed. Staff advised they were aware of the system to log maintenance requests and that issues were resolved in a timely manner. 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 which also included calibration of equipment. There was a system in place to ensure that the facility van was routinely maintained with registration and warrant of fitness remaining current. All staff who drive the van were required to have a driver's license with no previous driving convictions and a first aid certificate. The residents can enjoy different areas of the garden that are shaded and provide seating. The garden areas evidenced recent maintenance.

		Ramps and handrails facilitate ease of access around all areas of the facility. Corridors and bedrooms have sufficient space to enable residents to mobilise safely and independently. There was a system to identify, report and manage hazards. The facility has adequate space for equipment, and both individual and group activities. This includes two dining areas and two large lounge areas one of which the activity programme was held in. Private, quiet spaces were available for residents to meet with their visitors and partake in cultural activities. There were three wings of single bedrooms. Some bedrooms have ensuite toilets and there were communal toilets and showers in each wing. Bedrooms were of sufficient size for the resident to manoeuvre and have been personalised with the residents' own ornaments and memorabilia. 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 residents, whānau and staff. The environment was noted to be maintained at a satisfactory temperature. In the event of additions to the facility Māori consultation could be accessed via established links within the community and assistance from head office.
Subsection 4.2: Security of people and workforce The people: I trust that if there is an emergency, my service provider will ensure I am safe. Te Tiriti: Service providers provide quality information on emergency and security arrangements to Māori and whānau. As service providers: We deliver care and support in a planned and safe way, including during an emergency or unexpected event.	PA Moderate	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 emergencies. Staff records sampled evidenced that staff had completed this. Fire drills and emergency evacuations were completed at least six monthly with the most recent one completed in March 2024. Emergency exits were visible throughout the facility. The evacuation plan approved by Fire and Emergency New Zealand (FENZ) was sighted. Fire extinguishers were strategically placed throughout the facility and had been checked within the last 12 months

		by a contracted service. Whānau were advised of the facility's emergency responses as part of the admission process of their relative. Notices were prominent throughout the facility advising visitors of what action to take in the event of an emergency. The audit team were provided with necessary information on arrival at the facility regarding the action to take should an emergency occur whilst on site. All shifts had at least one staff member on duty with a current first aid certificate. This was confirmed by review of the rosters, staff records sampled and discussion with staff. The facility had an agreement with a community provider that ensured they were given priority to access a generator should the main supplies fail. Sufficient supplies of water were available to sustain residents and staff in the event of an emergency however supplies of food were inadequate. Additional emergency resources include a gas barbeque, torches, and civil defence supplies. Adequate stocks of personal protective equipment, incontinence products, and dressings were sighted. There was a functioning call bell system in place. It was noted that staff responded promptly when call bells were activated during the period of the audit. Senior afternoon staff were responsible for ensuring a security check of the facility occurs on dusk each evening ensuring all windows and doors were locked. A security company provides additional checks doing rounds each night and advising the FM of any security breaches. Security lighting, closed circuit television (CCTV) covering main entry points to the facility and regular checks on residents further enhanced the security of the facility. Doorbells need to be activated after dark to gain access to the facility. Staff confirmed their knowledge of security procedures.
Subsection 5.1: Governance The people: I trust the service provider shows competent leadership to manage my risk of infection and use antimicrobials appropriately. Te Tiriti: Monitoring of equity for Māori is an important	FA	The infection prevention (IP) and antimicrobial (AMS) programme had been approved by the board. Members of the board had access to an organisation that provided infection prevention strategies and advice. The clinical services manager collated a monthly infection report which was reported to the board via the executive leadership team. Infection prevention events were escalated immediately to the head of clinical

component of IP and AMS programme governance. As service providers: Our governance is accountable for ensuring the IP and AMS needs of our service are being met, and we participate in national and regional IP and AMS programmes and respond to relevant issues of national and regional concern.		services. Policies and procedures directed the management of the event using a stepwise and multidisciplinary team approach, that included for example the general practitioner, clinical coach and regional manager as appropriate.
Subsection 5.2: The infection prevention programme and implementation The people: I trust my provider is committed to implementing policies, systems, and processes to manage my risk of infection. Te Tiriti: The infection prevention programme is culturally safe. Communication about the programme is easy to access and navigate and messages are clear and relevant. As service providers: We develop and implement an infection prevention programme that is appropriate to the needs, size, and scope of our services.	FA	The IP programme implemented was suitable for the size and scope of the service provided. The programme was co-ordinated by the clinical services manager. The clinical services manager held a specific position description called the infection control co-ordinator (ICC) for this component of their employment. Relevant training had been completed and ongoing infection control training was also planned. The clinical services manager held the responsibility for decision making including overseeing, implementing, monitoring, and reporting of the IP programme. The clinical services manager had access to the clinical records and diagnostic results of residents. The clinical services manager's line of reporting was to the facility manager and to the head of clinical services, who was a member of the executive team. Procurement, building modifications, and other relevant policies and procedures were implemented following consultation with the clinical services manager, the facility manager and the head of clinical services. The IP programme, policies and procedures met requirements of this standard and reflected best practice. The programme had been reviewed annually, and monthly reports were provided to the executive team. Infection control was discussed at monthly staff and quality meetings. This was confirmed by staff and evident in meeting minutes. Policies and procedures were available for all staff to access. Staff confirmed knowledge of these policies and discussed how they accessed them. A current pandemic/infectious diseases response plan was documented and had been tested. Sufficient supplies of infection prevention resources and personal protective equipment (PPE) was available. Hand basins and hand sanitisers were readily available throughout the facility. Signage pertaining to hand hygiene was sighted during the audit.

		Annual organisational infection prevention education was provided to all staff. This was verified by education records sighted and staff interviews. In addition, topical education was provided at staff meetings. The clinical services manager had completed additional IP education delivered by the provider of the IP programme. Single use devices were not reused. This was verified during staff interviews and by observation during the audit. Reusable shared equipment for example sphygmomanometers, thermometers, and dressing scissors were decontaminated appropriately as per policy and the manufacturers recommendations. Appropriate materials for this process were observed during the audit, and staff discussed the procedure. Bedpans were sanitised after each use. Urinals were allocated to residents who required them and were for single resident use only. Hoist slings had been shared between residents, however during the audit a quality project was underway to ensure a sling was allocated to each resident requiring one, for single resident use only. The IP programme had a section relating to Māori cultural values. The section reflected the spirit of Te Tiriti O Waitangi and provided guidance to staff to ensure culturally safe practice. Staff interviewed confirmed they were aware of the policy, and provided examples of how tikanga practices were implemented. The clinical services manager described how information was provided to Māori in a culturally appropriate manner, that included whānau, and obtaining written information accessible via HealthEd (Ministry of Health) website. Residents and whānau confirmed that infection control issues and precautions had been discussed with them by staff, and the GP.
Subsection 5.3: Antimicrobial stewardship (AMS) programme and implementation The people: I trust that my service provider is committed to responsible antimicrobial use. Te Tiriti: The antimicrobial stewardship programme is culturally safe and easy to access, and messages are clear and relevant.	FA	There was an implemented antimicrobial policy that was appropriate to the size scope and complexity of the service. The policy had been approved by the board and was a component of the IP programme. Monthly reports were sighted that reported the number and type of infections, with an analysis that included the antibiotic course prescribed, and the causative organism identified by laboratory report where

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.		appropriate. The reports were reviewed by the clinical services manager and the head of clinical services to identify trends, or/and opportunities to reduce antimicrobial prescribing. The GP confirmed antibiotic prescribing occurred as per best practice guidelines sourced from Best Practice Advocacy Centre New Zealand (BPAC), and laboratory services. The clinical services manager had access to laboratory reports.
Subsection 5.4: Surveillance of health care-associated infection (HAI) The people: My health and progress are monitored as part of the surveillance programme. Te Tiriti: Surveillance is culturally safe and monitored by ethnicity. As service providers: We carry out surveillance of HAIs and multi-drug-resistant organisms in accordance with national and regional surveillance programmes, agreed objectives, priorities, and methods specified in the infection prevention programme, and with an equity focus.	FA	Surveillance of health care-associated infections was appropriate to the size and type of service. The surveillance programme was documented, and standard definitions were used relating to the type of infection acquired. Monthly surveillance data was collected and reported to the executive team, including ethnicity data. Trends and opportunities to improve were considered by the clinical services manager, and the head of clinical services. There were no trends identified in infection prevention documents sampled. The reports were discussed at staff meetings, and this was verified by staff. Clinical records verified that residents who developed an infection were informed and family/whānau were advised. The process was culturally appropriate as confirmed by residents and family. The service had not had any recent infection outbreaks. At the time of the audit there was one resident who was receiving treatment for an infectious condition.
Subsection 5.5: Environment The people: I trust health care and support workers to maintain a hygienic environment. My feedback is sought on cleanliness within the environment. Te Tiriti: Māori are assured that culturally safe and appropriate decisions are made in relation to infection prevention and environment. Communication about the environment is culturally safe and easily accessible. As service providers: We deliver services in a clean, hygienic environment that facilitates the prevention of infection and	FA	There were written policies that addressed the management of waste, and which reflected legislation and local bylaws. Observation during the audit confirmed that the policies were implemented, and that staff were familiar with the policies. All waste was securely stored and removed by appropriate contracted services. Medical waste products such as dressings were disposed in medical waste containers and removed by a biohazardous waste contractor. Material data safety sheets were accessible, and chemicals were stored securely. There was adequate personal protective equipment on site. Hazardous substances were identified on the hazard register. Oxygen cylinders were safely stored. Staff received orientation regarding the

transmission of antimicrobialresistant organisms.		management of waste and hazardous substances. Health and safety protocols were in place for needlestick injuries and body fluid exposure events. Yellow sharps containers were available. The laundering of bed linen and towels was outsourced by a contracted provider. Bed linen and towels visibly soiled were rinsed on site and placed in an alginate bag, then inside a colour coded linen bag. Other soiled linen was placed directly into the colour coded linen bag. All dirty linen bags were stored in a suitable area ready for transportation to the laundry. There was clear separation of the dirty and clean areas. Observation confirmed that clean bed linen and towels were stored in a designated area, free from dust and other forms of contamination. Resident's clothes and other laundry was washed and dried on site. The leader of the laundry service described the processes of separating clothes types and fabric types to maintain the quality of the clothing. Detergents were dispensed from an in-line system. There were four cleaning trolleys. These were observed to be covered and locked when not in use during working hours. There was a room to lock the trolleys in, outside of working hours. An in-line system was used to dispense cleaning products. A cleaner discussed the procedures documented including routine and terminal cleans of rooms. Regular cleaning and laundry audits were performed, and corrective actions were undertaken as required. The audits were presented at IP and quality meetings. Clients and whānau confirmed satisfaction with the cleanliness of the facility, equipment and all amenities, they also stated that the laundry service met expectations.
Subsection 6.1: A process of restraint The people: I trust the service provider is committed to improving policies, systems, and processes to ensure I am free from restrictions. Te Tiriti: Service providers work in partnership with Māori to ensure services are mana enhancing and use least restrictive practices.	FA	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 which ensured consistency across all UCG facilities. The UCG clinical lead was the restraint coordinator at Kensington Court. If restraint were to be considered, the decision-making escalation

As service providers: We demonstrate the rationale for the use of restraint in the context of aiming for elimination.		process required input form the executive leadership team. Staff confirmed the organisations approach to elimination of restraint and management of behavioural challenges though alternative means. The safety of residents and staff was always considered by the facility and executive team, and this was discussed. 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 with documentation confirming this. 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 and that there were processes in place that ensured Māori/whānau oversight would be provided. The executive team 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. There were no episodes of restraint recorded since the last audit. Restraint would only be considered as a last resort.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 4.2.7 Alternative essential energy and utility sources shall be available, in the event of the main supplies failing.	PA Moderate	Discussion with staff and review of emergency food stored revealed supplies were inadequate and inappropriate.	Supplies of food stored for emergencies were inadequate to sustain residents and staff for three days in the event of a civil defence emergency. Much of the food supplies that were available were inappropriate and unable to be cooked on a barbeque or prepared in the event of an emergency.	Ensure emergency food supplies stored are adequate and appropriate to sustain all residents and staff on site for three days. 60 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.