

# Ilam Lifecare Limited - Ilam Lifecare

---

## Introduction

This report records the results of a Certification Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

<b>Legal entity:</b>	Ilam Lifecare Limited
<b>Premises audited:</b>	Ilam Lifecare
<b>Services audited:</b>	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 7 September 2016      End date: 8 September 2016
<b>Proposed changes to current services (if any):</b>	As part of this audit, the service was assessed as suitable to provide medical services. Seven rest home rooms located near the rest home nurses station were assessed as suitable for dual-purpose beds.
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	123



# 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 outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. 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 standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

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

## General overview of the audit

Ilam Lifecare rest home and hospital and retirement village is part of the Arvida aged care residential group. The service provides dementia, rest home and hospital level of care for up to 76 residents in the care centre and up to 47 rest home level of care in serviced apartments. On the day of the audit there were 123 residents which included 14 residents at rest home level in serviced apartments.

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the District Health Board. The audit process included the review of policies and procedures, the review of resident and staff files, observations, and interviews with family, management, staff and the general practitioner.

An experienced village manager, who is a registered nurse is responsible for the daily operations of the service. She is supported by clinical manager, training coordinator, quality manager and stable workforce.

The residents and relatives spoke positively about the care and services provided at Ilam Lifecare.

This certification audit identified areas for improvement relating to progress notes and care plans.

The service has been awarded a continuous improvement rating around activities for rest home residents in the serviced apartments and the reduction of challenging behaviours in dementia care.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.

All standards applicable to this service fully attained with some standards exceeded.

Staff at Ilam Lifecare strive to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner's Code of Consumers' Rights (the Code). Residents' cultural needs are met. Policies are implemented to support residents' rights, communication and complaints management. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns have been managed and a complaints register is maintained.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.

Standards applicable to this service fully attained.

The quality and risk management programme includes service philosophy, goals and a quality/business planner. Meetings are held to discuss quality and risk management processes. Residents/family meetings are held regularly and residents and families are surveyed annually. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and followed through. A comprehensive education and training programme has been implemented with a current training plan in place. Appropriate employment processes are adhered to and all employees have an annual staff appraisal completed. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
--	--	---

There is a comprehensive admission package available prior to or on entry to the service. The registered nurses are responsible for each stage of service provision. A registered nurse completes the assessments, care plans and evaluations with the resident and/or family/whānau input. Care plans viewed in resident records demonstrated service integration and were evaluated at least six monthly. Resident files included medical notes by the general practitioner and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and senior caregivers responsible for administration of medications complete education and medication competencies. The medication charts reviewed met legislative prescribing requirements and were reviewed at least three monthly by the general practitioner.

A separate activity programme is implemented for residents at each level of care including rest home residents in serviced apartments. The programme includes community visitors and outings, entertainment and activities that meet the individual recreational, physical, cultural and cognitive abilities and preferences for each resident group. Residents and families report satisfaction with the activities programme.

Residents' food preferences and dietary requirements are identified at admission and all meals are cooked on site. The kitchen is well equipped for the size of the service. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met. Additional nutritious snacks are available at all times.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
--	--	--

There are documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. Chemicals are stored safely throughout the facility. The building holds a current warrant of fitness. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade. Resident bedrooms are personalised with a mix of ensembles and communal facilities. Documented policies and procedures for the cleaning and laundry services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services. Documented systems are in place for essential, emergency and security services. There is a staff member on duty at all times with a current first aid certificate.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
---	--	--

Ilam Lifecare has restraint minimisation and safe practice policies and procedures in place. Staff receive training around restraint minimisation and the management of challenging behaviour. During the audit four residents were using restraints and there were no residents using enablers. The clinical manager is the designated restraint coordinator.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.

Standards applicable to this service fully attained.

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is reviewed annually and meets the needs of the service. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

## Summary of attainment

The following table summarises the number of standards 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)
<b>Standards</b>	2	47	0	1	0	0	0
<b>Criteria</b>	2	98	0	1	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) policy and procedure is implemented. Discussions with eight caregivers, four registered nurses (RN) and diversional therapists confirm their familiarity with the Code. Interviews with seven residents (four rest home and three hospital) and seven families (four hospital, one rest home in serviced apartment and two dementia care) confirm the services being provided are in line with the Code. The Code is discussed at resident, staff and quality meetings.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	
Standard 1.1.11: Advocacy And Support	FA	A policy describes access to advocacy services. Staff receive training on advocacy. Information about accessing advocacy services information is available in the entrance foyer. This includes advocacy contact details. The information pack provided to residents at the time of entry to the

Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.		service provides residents and family/whānau with advocacy information. Advocate support is available if requested. Interviews with staff and residents informed they are aware of advocacy and how to access an advocate.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community.	FA	Residents are encouraged to be involved in community activities and maintain family and friends networks. On interview, all staff stated that residents are encouraged to build and maintain relationships. Residents interviewed confirmed that relative/family visiting could occur at any time.
Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The service has a complaints policy that describes the management of complaints process. There is a complaints form available. Information about complaints is provided on admission. Interview with residents demonstrated an understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints. There is a complaints register. Verbal and written complaints are documented. All complaints reviewed had noted investigation, timeframes and corrective actions, when and where required and resolutions were in place. Results are fed back to complainants. A complaint made to the Health and Disability Commission in January 2016 was investigated with corrective actions put in place and resolutions completed. A letter from the Health and Disability Commission in March 2016 confirmed that no further action would be taken.
Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights.	FA	There are posters of the Code on display throughout the facility and leaflets are available in the foyer of the facility. The service is able to provide information in different languages and/or in large print if requested. Information is also given to next of kin or enduring power of attorney (EPOA) to read with the resident and discuss. On entry to the service, the village manager or clinical manager discusses the information pack with the resident and the family/whānau. The information pack includes a copy of the Code.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner	FA	The service has policies that align with the requirements of the Privacy Act and Health Information Privacy Code. Staff were observed respecting residents' privacy and could describe how they manage maintaining privacy and respect of personal property. All residents interviewed stated their needs were met. There is a policy that describes spiritual care. Church services are conducted regularly. All residents interviewed indicated that residents' spiritual needs are being met when

that has regard for their dignity, privacy, and independence.		required. The village manager is the privacy officer and has an open door policy.
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	The service has established cultural policies to help meet the cultural needs of its residents. One resident identified as Māori on the days of the audit. There is a Māori health plan. Cultural and spiritual practice is supported and identified needs are incorporated into the care planning process and review as demonstrated in the resident files sampled. Discussions with staff confirm that they are aware of the need to respond to cultural differences.
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	The service has established cultural policies aimed at helping meet the cultural needs of its residents. All residents interviewed reported that they were satisfied that their cultural and individual values were being met. Information gathered during assessment including residents' cultural beliefs and values, is used to develop a care plan in consultation with the resident (if appropriate) and/or their family/whānau. Staff receive training on cultural safety/awareness.
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	The facility has a staff code of conduct which states there will be zero tolerance against any discrimination occurring. The abuse and neglect processes cover harassment and exploitation. All residents interviewed reported that the staff respected them. Job descriptions include responsibilities of the position, ethics, advocacy and legal issues. The orientation and employee agreement provided to staff on induction includes standards of conduct.
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	CI	The service has policies to guide practice that align with the health and disability services standards, for residents with aged care needs. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training. Residents and families interviewed spoke positively about the care and support provided. Staff interviewed had a sound understanding of principles of aged care and stated that they feel supported by the management team. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training. The service has successfully reduced the number of challenging behaviours in the dementia unit.

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Residents interviewed stated they were welcomed on entry and given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Incident/accidents forms reviewed had documented evidence of family notification or noted if family did not wish to be informed.</p> <p>Relatives interviewed confirmed that they are notified of any changes in their family member's health status. A residents/relatives meeting occurs every three months and issues arising from the meeting are communicated to staff. Any issues raised from these meetings are investigated by the village manager and there was evidence of implemented corrective actions. Interpreter services are available as required.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Ilam Lifecare is owned and operated by the Arvida Group. The service is certified to provide rest home, hospital and dementia level care in dedicated purpose built wings for up to 123 residents including rest home level care across 22 rest home beds, and 47 LTO serviced apartments; hospital level care across 34 hospital beds; and dementia level care across 20 dementia beds. Seven rest home bedrooms have been assessed as suitable for dual-purpose. On the day of the audit occupancy was 89 residents including 22 rest home residents, 14 rest home level care in serviced apartments, 33 hospital residents and 20 dementia level care residents (including one resident on respite care). All residents were admitted under the aged related residential care contact (ARRC). The service was verified as suitable to provide medical level care under their current hospital certification.</p> <p>The village manager is an experienced aged care manager and RN who has held the position for five years. The village manager is a registered nurse with postgraduate qualifications in aged care and health auditing. She is supported by a clinical manager who has been in the role for 12 years and a quality manager who has been in the position for five years at Ilam Lifecare.</p> <p>The village manager reports to the general manager of operations and provides a monthly report. Arvida has an overall business/strategic plan. Ilam Lifecare has a facility quality and risk management plan in place for the current year and business goals plan for 01 April 2016 – 31 March 2017. The organisation has a philosophy of care, which includes a mission statement. Ilam Lifecare is currently transitioning to the Arvida Group quality management systems and Arvida policies and procedures. The village manager has completed relevant training of over eight hours in the last 12 months.</p>

<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>In the absence of the village manager, the clinical manager is in charge. Support is also provided by the general manager of wellness and care.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>There is a business/strategic plan that includes quality goals and risk management plans for Ilam Lifecare. Interviews with staff confirmed that there is discussion about quality data at various staff meetings. The village manager advised that she is responsible for providing oversight of the quality programme on site, which is also monitored at organisational level. The quality and risk management programme is designed to monitor contractual and standards compliance. The site-specific service's policies are being transitioned over to the Arvida Group policies, which will be reviewed at least every 2 years across the group. Head office sends new/updated policies. Ilam Lifecare has implemented the Arvida Group InterRAI assessment policy. Staff have access to policy manuals.</p> <p>Data is collected in relation to a variety of quality activities and an internal audit schedule has been completed. Areas of non-compliance identified through quality activities are actioned for improvement. The internal audit programme continues to be implemented and all issues identified had corrective action plans and resolutions. All staff interviewed could describe the quality programme corrective action process. There is an annual staff training programme that is implemented and based around policies and procedures and records of staff attendances maintained. Residents/relatives are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families. The 2016 resident relative survey overall result shows satisfaction with services provided. Resident/family meetings occur every three months and resident and families interviews confirmed this.</p> <p>There is an implemented health and safety, and risk management system in place including policies to guide practice. There is a current hazard register. Staff confirmed they are kept informed on health and safety matters at staff meetings. The facility completed the ACC tertiary level in January 2016. Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls.</p>

<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>There is an accidents and incidents reporting policy. The clinical manager investigates accidents and near misses and analysis of incident trends occurs. There is a discussion of incidents/accidents at staff meetings including actions to minimise recurrence. A registered nurse conducts clinical follow-up of residents. Twelve incident forms reviewed demonstrated that appropriate clinical follow-up and investigation occurred following incidents. Discussions with the village manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. Five section 31 incident notification forms (sighted) were completed in the past 12 months.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>There are human resource management policies in place. This includes that the recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates is kept. Eleven staff files were reviewed (one village manager, one clinical manager, one quality manager, one training coordinator, two RNs, two caregivers, one cleaner, one laundry and one chef) and there is evidence that reference checks were completed before employment was offered. Annual staff appraisals were evident in all staff files reviewed. Completed orientation is on file and staff described the orientation programme. The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice.</p> <p>The in-service education programme for 2015 has been completed and the plan for 2016 is being implemented. Staff are supported to complete an aged care education programme with a dedicated aged care programme training coordinator. Interview with staff confirmed a range of education was provided in a variety of formats two to three times per month.</p> <p>Seventeen out of nineteen caregivers who are employed in the dementia care unit have completed their dementia specific units. Two caregivers are in the progress to complete their dementia specific units and have commenced work in the last 12 months. The village manager and clinical manager attend external training, including sessions provided by the local DHB. Discussions with the caregivers and the RNs confirmed that ongoing training is encouraged and supported by the service. Eight hours of staff development or in-service education has been provided annually.</p> <p>The training programme is relevant for staff to deliver hospital medical services and includes education around medical conditions including palliative care.</p>
<p>Standard 1.2.8: Service Provider Availability</p>	<p>FA</p>	<p>Staff rostering and skill mix policy is in place. Sufficient staff are rostered on to manage the care requirements for residents in the rest home, serviced apartments, dementia and hospital wings.</p>

<p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>RNs are rostered on 24/7 in the hospital unit and provide afterhours and weekend call to the rest home, serviced apartments and dementia unit. Rosters are and can be adjusted to reflect occupancy and resident acuity. The village and clinical and training managers are responsible staff recruitment and for managing the roster. The village manager is employed full time. The quality manager works two days per week. The clinical manager works five days per week.</p> <p>In the hospital unit, there is an RN rostered on every shift with seven caregivers in the morning, six caregivers in the afternoon and two caregivers on at night. One of the night caregivers covers the serviced apartment residents.</p> <p>In the rest home, there is an RN rostered on every shift, also overseeing the serviced apartments and dementia wing in the afternoon and at night, plus two caregivers in the morning, two caregivers in the afternoon and one caregiver on at night.</p> <p>In the dementia wing, there is an RN rostered on the morning shift Monday - Friday, two caregivers in the morning, two caregivers in the afternoon and one caregiver on at night.</p> <p>In the serviced apartments, there is an RN rostered on the morning (Mon-Fri) with oversite rest home RN covering the afternoon and at night, two caregivers in the morning, two caregivers in the afternoon and one hospital caregiver covering at night.</p> <p>The service proposes to increase the number of caregivers on each shift in the rest home as hospital level residents occupy dual-purpose beds.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Residents' files are protected from unauthorised access by being locked away in the nurses' stations. Other residents or members of the public cannot view sensitive resident information.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>Residents' entry into the service is facilitated in a competent, equitable, timely and respectful manner. Admission information packs on the services and levels of care are provided for families and residents prior to admission or on entry to the service. There is specific information provided for families in the dementia unit. All admission agreements reviewed (for long-term residents) align with all contractual requirements. Exclusions from the service are included in the admission agreement.</p>

<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>Planned exits, discharges or transfers were coordinated in collaboration with the resident and family to ensure continuity of care. There were documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. The residents and their families were involved for all exit or discharges to and from the service.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. Staff who administer medications (RNs and senior caregivers) have been assessed for competency on an annual basis. Registered nurses have completed medication competencies that are also relevant to medical services including syringe driver training and subcutaneous fluids. Annual education around safe medication administration has been provided. The service introduced an electronic medication system September 2015. There is documented evidence (on the electronic system) of medication reconciliation on delivery of medications. Medication fridges are checked weekly and are maintained within the acceptable temperature range. All eye drops and ointments were dated on opening. Standing orders are not used. There were no residents self-medicating on the day of audit.</p> <p>Twenty medication charts (eight hospital, six rest home and six dementia care) reviewed met legislative requirements.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>All meals are prepared and cooked on site by a qualified chef. The chef on duty is supported by morning and afternoon kitchenhands. Food services staff have attended food safety training during orientation and ongoing through self-learning tools. Two cooks are currently completing unit standards. The four weekly seasonal menu has been reviewed by a dietitian July 2016. Cultural preferences and special diets are met. Resident dislikes are known and accommodated. The chef receives a resident dietary profile for new and respite care residents, and is notified of any dietary changes. Likes and dislikes are known. Special diets are accommodated including high protein, gluten free, diabetic desserts and modified foods. A dumb waiter is used for the transport of meals in hot boxes from the kitchen. Nutritious snacks are available 24 hours in the dementia care unit.</p> <p>Fridge and freezer temperatures are taken and recorded daily. End cooked food temperatures are recorded daily. Perishable foods sighted in all fridges were dated. The dishwasher is checked regularly by the chemical supplier. Staff have received training in chemical safety. Chemicals are stored safely. A maintenance and cleaning schedule is maintained.</p> <p>Resident meetings and surveys, along with direct input from residents, provide resident feedback on the meals and food services generally. Residents and family members interviewed were satisfied</p>

		with the food and confirmed alternative food choices were offered for dislikes.
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	There is an admission information policy. The reasons for declining entry would be if the service is unable to provide the level of care required or there are no beds available. Management communicate directly with the referring agencies and family/whānau as appropriate if entry was declined.
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	The RN completes an initial assessment on admission including risk assessment tools. An interim assessment is undertaken within 21 days of admission and six monthly, or earlier due to health changes. Nine of ten resident files reviewed contained InterRAI assessment notes and summaries. One resident under respite care had an initial assessment completed but not required to have an InterRAI assessment. Resident needs and supports are identified through available information such as discharge summaries, medical notes and in consultation with significant others and included in the long-term care plans (link 1.3.5.2).
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	PA Low	<p>Resident care plans reviewed were resident focused and individualised. Not all support needs as assessed were included in the long-term care plans reviewed. Short-term care plans are used for changes to health status and have either been resolved or if ongoing, transferred to the long-term care plan. Care plans evidenced resident (as appropriate) and family/whānau involvement in the care plan process. Relatives interviewed confirmed they were involved in the care planning process. Resident files demonstrate service integration.</p> <p>The three dementia care resident files reviewed had 24-hour activity plans with documented behaviours, triggers and activities to distract and de-escalate behaviours. The long-term care included a detailed behaviour management plan.</p> <p>There was evidence of allied health care professionals involved in the care of the resident including physiotherapist, podiatrist, dietitian and community mental health services.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p>	FA	When a resident's condition alters, the registered nurse initiates a review and if required, GP, nurse specialist consultation. There is documented evidence on the family contact form in each resident

<p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>file that evidences family were notified of any changes to their relative's health including (but not limited to) accident/incidents, behaviours, infections, health professional visits, referrals and changes in medications. Discussions with families and notifications are documented on the family/whānau/representative sheet in the resident files reviewed.</p> <p>Adequate dressing supplies were sighted in treatment rooms. Wound management policies and procedures are in place. Wound assessment and treatment forms, ongoing evaluation form and evaluation notes were in place for nine hospital residents, one rest home and one dementia care resident with wounds, including two chronic wounds. There were no pressure injuries. There is evidence of wound nurse specialist involvement in wound management as required.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified.</p> <p>Residents are weighed monthly or more frequently if weight is of concern. Nutritional requirements and assessments are completed on admission identifying resident nutritional status and preferences. Monitoring occurs for weight, vital signs, blood glucose, and pain, challenging behaviour, food and fluid charts.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>CI</p>	<p>The service employs a qualified diversional therapist (DT) for the rest home and two DTs training, one for the hospital residents and one in the dementia care unit. The service employed a DT for the studio apartments, which has provided improved access to activities for rest home residents. The activity programme is implemented Monday to Friday for rest home and hospital residents and seven days a week in the dementia care unit.</p> <p>The activity team provide individual and group activities for each unit that meets the abilities and preferences of the residents. There are integrated activities for all residents such as entertainers and church services. Community links include visiting schoolchildren, inter-home bowls, shopping and visits into the community. One-on-one activities such as individual walks, reading and chats and hand massage occur for residents who are unable to participate or choose not to be involved in group activities. Themes and events are celebrated. There are regular outings for all residents. A mobility taxi is hired monthly for hospital resident outings.</p> <p>A diversional therapy resident profile is completed on admission. Individual activity plans were seen in long-term resident files. The activity team are involved in the six monthly multidisciplinary review. The service receives feedback and suggestions for the programme through surveys and two monthly resident meetings.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>All initial care plans for long-term residents were evaluated by the RN within three weeks of admission. Long-term care plans have been evaluated by the multidisciplinary team at least six monthly or earlier for any health changes. Written evaluations identified if the resident/relative desired goals had been met or unmet. Family are invited to attend the MDT review and are informed of any changes if unable to attend. The GP reviews the residents at least three monthly or earlier if required. Ongoing nursing evaluations occur as indicated and are documented within the progress notes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>Referral to other health and disability services is evident in the resident files sampled. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files.</p> <p>There are documented policies and procedures in relation to exit, transfer or transition of residents. The residents and the families are kept informed of the referrals made by the service.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>Documented processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. Material safety datasheets are readily accessible for staff. Chemicals are stored in locked areas throughout the facility. Personal protective clothing is available for staff and seen to be worn by staff when carrying out their duties on the day of audit. Staff have completed chemical safety training provided by the chemical supplier.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The building has a current building warrant of fitness that expires 1 September 2017. The building has two levels with hospital level beds on the first floor. Serviced apartments are on the first floor and ground floor. The rest home and dementia care wing are on the ground floor. There is stair and lift access between the floors.</p> <p>The service employs two maintenance persons who job-share the maintenance role. The maintenance person ensures daily maintenance requests are addressed and a planned maintenance schedule is maintained. Essential contractors are available 24 hours. Electrical testing is completed annually. Annual calibration and functional checks of medical equipment including hoists, is completed by an external contractor. The maintenance person carries out regular visual and physical checks of transferring equipment, beds and call bells. Hot water temperatures in</p>

		<p>resident areas are monitored. Temperature recordings reviewed were maintained below 45 degrees Celsius.</p> <p>The facility has wide corridors with rails and sufficient space for residents to safely mobilise using mobility aids or for the use of hoists and hospital recliners on wheels. There is safe access the outdoor areas. Seating and shade is provided. There is an outdoor covered balcony area for hospital residents to access.</p> <p>The dementia care unit has secure access. There is free access to safe outdoor gardens, walking pathways and an internal courtyard.</p> <p>The caregivers and RNs interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>All resident rooms in the rest home and hospital wings have ensuites. Ensuite toilets and shower facilities are of an appropriate design to meet the needs of the residents. There are toilet facilities located near communal areas with privacy locks. Residents interviewed confirm care staff respect the residents' privacy when attending to their personal cares. The dementia wing resident bedrooms all have hand basins. There are adequate numbers of communal showers and toilet facilities.</p> <p>Seven bedrooms in the rest home wing (assessed for dual-purpose) have sufficient space to manoeuvre a hoist within the ensuite.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>All rooms are single. There is adequate room to safely manoeuvre mobility aids and transferring equipment such as hoists in the resident bedrooms in each wing for each level of care. There is sufficient space in the seven bedrooms assessed for dual-purpose to safely deliver hospital level if care including the use of hoists. Residents and families are encouraged to personalise bedrooms. A tour of the facility evidenced personalised rooms including the residents own furnishing and adornments.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and</p>	FA	<p>The rest home wing has a large main lounge, smaller lounge, library and internet area and an activities lounge. The bi-fold doors between the activities lounge and main lounge can open up to provide a large entertainment area. The rest home dining room provides tea and coffee making facilities for residents and visitors.</p> <p>The hospital wing has a separate dining room with a functioning kitchenette. The main lounge is</p>

<p>accessible areas to meet their relaxation, activity, and dining needs.</p>		<p>spacious and accommodates specialised hospital lounge chairs. There is a smaller sun lounge area and seating alcoves.</p> <p>The dementia wing has seating in the main lounge designed to allow both individual and small group activities to occur. The dining room is open plan with a safe kitchenette area. There is a smaller lounge for quiet activities or visitors.</p> <p>All communal areas are accessible to residents. Care staff assist or transfer residents to communal areas for dining and activities as required.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>There are policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. There are dedicated laundry and cleaners on duty seven days a week. The laundry and cleaning staff have completed chemical safety training and self-learning tools for laundry and cleaning processes. The laundry has an entry and exit door. A laundry chute in the upstairs hospital wing is used to deliver laundry bags to the laundry. The cleaner's trolleys are stored in a locked area when not in use. There is keypad access from the rest home wing and the dementia wing room into a shared sluice room and there is an upstairs sluice room for the hospital wing. Internal audits monitor the effectiveness of the cleaning and laundry processes. The chemical supplier conducts quality checks on the effectiveness of washing and cleaning processes.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Six monthly fire evacuation practice documentation was sighted. A contracted service provides checking of all facility equipment including fire equipment. Fire training and security situations are part of orientation of new staff and include competency assessments. Emergency equipment is available at the facility. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and gas cooking. Short-term backup power for emergency lighting is in place. A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is available at all times. There are call bells in the residents' rooms, and lounge/dining room areas. Residents were observed to have their call bells in close proximity.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with</p>	<p>FA</p>	<p>Residents were provided with adequate natural light and safe ventilation. Underfloor heating provides an environment that is maintained at a safe and comfortable temperature. The residents and family interviewed confirmed temperatures were comfortable during the summer and winter</p>

adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.		months.
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The clinical manager is the infection control coordinator who has a job description that outlines the responsibility of the role. The infection control committee meet monthly and provides reports to management and staff. The infection control programme has been reviewed annually.</p> <p>Visitors are asked not to visit if they are unwell. Hand sanitisers were appropriately placed throughout the facility. Residents are offered the annual influenza vaccine.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The infection control coordinator has attended infection control education within the Arvida group and through attendance at infection control education provided by an infection control consultant. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The infection control coordinator and infection control committee have good support from the Arvida Group head office, the infection control nurse specialist at the DHB, laboratory technician, GPs and public health.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>There are infection control policies and procedures appropriate to for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies have been reviewed and transitioned over to the Arvida Group infection control policies.</p>
Standard 3.4: Education	FA	<p>The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred and includes a self-learning tool.</p>

<p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>		<p>Infection prevention and control is part of the staff orientation process.</p> <p>Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Infection surveillance is an integral part of the infection control programme and is described in the Arvida group infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. Short-term care plans are used for infections. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at facility meetings. Benchmarking occurs and graphs and are displayed for staff. If there is an emergent issue, it is acted upon in a timely manner. There has been one outbreak in March 2016. Documentation demonstrated the outbreak was well managed. The relevant authorities were notified.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The service has documented systems in place to ensure the use of restraint is actively minimised. There were four residents with four restraints (three bedrails and one chair brief support) and no residents using an enabler during the audit. Staff interviews and staff records evidence guidance has been given on restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. Staff education on restraint minimisation and management of challenging behaviour has been provided.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	<p>FA</p>	<p>The clinical manager is the designated restraint coordinator. Assessment and approval process for restraint use included the restraint coordinator, RNs, resident/or representative and medical practitioner.</p>

<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>The service completes assessments for residents who require restraint or enabler interventions. These were undertaken by suitably qualified and skilled staff, in partnership with the family/whānau, in the four restraint files sampled. The restraint coordinator, the resident and/or their representative and a medical practitioner were involved in the assessment and consent process. In the files reviewed, assessments and consents were fully completed.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>Assessments identify the specific interventions or strategies trialled before implementing restraint. Approved restraints are documented. Restraint authorisation is in consultation/partnership with the resident and family and the restraint coordinator. Two of four residents on restraint did not have interventions documented to manage the risks associated with restraint use documented in the care plan (link 1.3.5.2). A restraint register is in place providing an auditable record of restraint use and is completed for all residents requiring restraints.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>The restraint minimisation manual identifies that restraint is only put in place where it is clinically indicated and justified, and approval processes are obtained/met. The service has documented evaluation of restraint every month. In the files reviewed, evaluations had been completed with the resident, family/whānau and restraint coordinator.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>Restraint practices and use, education needs and individual care plans are reviewed on a formal basis every month by the restraint coordinator at quality meetings. Evaluation timeframes are determined by policy and risk levels.</p>

## Specific results for criterion where corrective actions are required

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

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	PA Low	<p>Two hospital, two rest home and two dementia level of care long-term care plans reflected the outcomes of assessments and supports required to achieve the residents desired goals. Two of four hospital residents with restraint did not document the risks associated with restraint use in the long-term care plans.</p>	<p>1) Two hospital, one rest home and one dementia care resident’s long-term care plans did not document supports to meet the current needs of the residents as follows; a) two hospital residents assessed at high risk of pressure injury did not have appropriate pressure injury preventions documented in the long-term care plan. The long-term care plan of one of the residents assessed at high risk of falls, did not document appropriate falls prevention strategies. b) The long-term care plan for one rest home resident did not reflect the outcome of the InterRAI assessment for falls and associated knee pain. c) There were no documented interventions for the monitoring of oedematous legs as per GP medical notes.</p> <p>2) The long-term care plans of two hospital residents on restraint did not identify the risks associated with restraint use. Interviews with staff and observation of residents identified that appropriate care in managing risk is being implemented and therefore this criterion has been identified as low risk.</p>	<p>1) Ensure long-term care plans reflect the resident clinical risks and current health status. 2) Ensure the risks associated with restraint use are documented in the long-term care plans.</p> <p>90 days</p>

--	--	--	--	--

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

As well as whole standards, individual criterion within a standard 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 standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>The service has identified that clinical reporting to appropriate meetings has been a great improvement since last audit. They have implemented facility, clinical managers and training coordinator reports for the monthly quality meetings. The service is currently developing KPIs within the Arvida Group. However, they are still to set group benchmarking but Ilam have continued with internal benchmarking with five other facilities. The service is proactive in implementing quality improvements. The following have been implemented (but not limited to) dietary needs, residents diversional therapy in apartments, needle stick injuries – prevention, H&amp;S injury prevention initiatives for staff and H&amp;S</p>	<p>The service identified an increase in challenging behaviours in February (four) and March (five) in 2016. There were staff incidents reported in relation to challenging behaviours with two in March and four in June 2016. In July 2016, the service implemented an action plan to reduce the number of challenging behaviours. There was a team approach to implement the “Cressy goals” including improved communication and mentoring and training sessions for all staff. There were regular meetings held with the clinical manager, charge nurse, diversional therapist and caregivers to identify individual resident de-escalation techniques. All behaviour assessments, behaviour charts and 24-hour care plans were reviewed to ensure all triggers and alternative de-escalation strategies were documented to inform staff of early warning signs and interventions that were successful. Meaningful activities to reduce behaviours have been introduced including free access to a cookie and sweet jar and finger foods in the dining room. Monthly evaluations evidence the implemented goals have been successful in achieving desired delivery of care and harmonious environment for residents and staff. In July and August 2016</p>

		Safe use of knife training for kitchen staff.	there were no challenging incidents or staff incidents reported.
Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.	CI	The number of rest home residents in studios units had increased from five in October 2015 to 10 in February 2016. Residents reported a lack of stimulation around activities. The service identified a need to provide a stimulating and aired activities programme for the increasing number of rest home residents in studio apartments.	A DT was appointed in January 2016 for 24 hours per week to implement an activity programme for the rest home residents in studio apartments. A variety of activities have been offered including news, word games, “keep moving” exercises, choir, music, knitting and walking groups and social interactions. There are weekly outings to community events, cafes, wineries and shopping trips. The rest home residents are encouraged to attend other activities offered in the care centre. A survey of 13 rest home residents in studio apartments conducted August 2016 evidenced 98% satisfaction with the activity programme.

End of the report.