

Presbyterian Support Services (South Canterbury) Incorporated - Wallingford Rest Home

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 BSI Group New Zealand Ltd, 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:

Legal entity:	Presbyterian Support Services (South Canterbury) Incorporated
Premises audited:	Wallingford Rest Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 10 May 2021 End date: 11 May 2021
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:	31



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
	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
	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

Wallingford Rest Home is one of three aged care facilities managed by the Presbyterian Support South Canterbury (PSSC) organisation. Wallingford Rest Home provides care for up to 32 rest home level residents. At the time of the audit there were 31 rest home residents.

Presbyterian Support South Canterbury has an organisational structure that supports continuity of care and support to residents. Presbyterian Support South Canterbury continue to utilise the Eden model of care and maintain a strong resident focus. The nurse manager has been in the role for ten years and is supported by an administration/care manager, three registered nurses, PSSC management and Wallingford Rest Home caregivers. Residents, relatives and the general practitioner interviewed spoke positively about the care and support provided.

This certification audit was conducted against the health and disability sector standards and the district health board contract. The audit process included the review of policies and procedures, the review of resident and staff files, observations and interviews with residents, relatives, staff, management and the GP.

This certification audit identified Wallingford rest home meets the health and disability sector standards.

The service is commended for achieving continuous improvements around good practice and the activities programme.

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.
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The service adheres to the Health and Disability Commissioner's Code of Health and Disability Consumers' Rights (the Code). The personal privacy and values of residents are respected. Māori health strategies are being implemented. Individual care plans reference the cultural needs of residents. Discussions with residents and relatives confirmed that residents and where appropriate their families are involved in care decisions. Regular contact is maintained with families including if a resident is involved in an incident or has a change in their current health. Families and friends are able to visit residents at times that meet their needs. Examples of good practice were provided. There is an established system for the management of complaints, which meets guidelines established by the Health and Disability Commissioner.

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.
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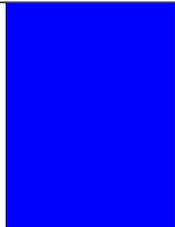
Services are planned, coordinated, and are appropriate to the needs of the residents. The nurse manager is responsible for day-to-day operations. Quality goals are documented with evidence of monthly reviews. Quality and risk data is collected, analysed and discussed. Corrective actions are implemented and evaluated where opportunities for improvements are identified.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. Ongoing education for staff is implemented and includes competency assessments.

Registered nursing onsite cover is provided six days. An RN is available on call 24/7. Residents and families reported that staffing levels are adequate to meet the needs of the residents.

The integrated residents' files are appropriate to the service type.

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.		All standards applicable to this service fully attained with some standards exceeded.
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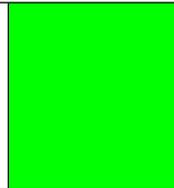
All admissions to the service are centralised through the PSSC resident liaison manager. There is a comprehensive information package for residents/relatives on admission to the service. The registered nurses complete interRAI assessments, and care planning. Care plans demonstrate service integration. Care plans were updated for changes in health status. The activity programmes meet the ability and needs of residents and meets the Eden model of care. There is provision for group and individual one-on-one activities. The residents are active in the community.

There are policies and processes that describe medication management that align with accepted guidelines. Staff responsible for medication administration have completed annual competencies and education. The general practitioner reviews medications three-monthly.

A dietitian designs the menu and visits each site monthly. Individual and special dietary needs are accommodated. All meals and baking are prepared and cooked on site. Residents interviewed responded favourably to the food provided.

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.

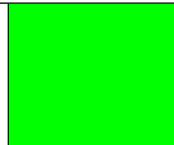


Standards applicable to this service fully attained.

Wallingford rest home has a current building warrant of fitness. Reactive and preventative maintenance is carried out. Medical equipment and electrical appliances have been calibrated. All bedrooms are single occupancy. There is sufficient space to allow the movement of residents around the facility using mobility aids. There are a number of lounge and dining areas throughout the facility. External garden areas are well maintained, easily accessible and provide seating and shade. There are dedicated housekeeping/laundry staff who provide housekeeping and laundry services across seven days a week. Policies and procedures are in place for essential, emergency and security services, with adequate supplies should a disaster occur. There is staff on duty 24/7 and on outings with a current first aid certificate. The facility is adequately heated, and all resident rooms have external windows.

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.

Staff regularly receive training around restraint minimisation and the management of challenging behaviour. There are no restraints or enablers used in the service.

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.

There is a PSSC infection control coordinator who oversees infection control practices across the organisation. There is an infection control programme in place which is appropriate to the size and complexity of the organisation which is reviewed annually. There is an infection control committee representative of the organisation who meet three-monthly. Data is collated and analysed monthly and reported three-monthly at appropriate meetings. Covid-19 was well prepared for, training occurred, staff residents and relatives were updated regularly, and adequate supplies of personal protective equipment was sighted. There have been no outbreaks since the previous audit.

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)
Standards	2	43	0	0	0	0	0
Criteria	2	91	0	0	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)
Standards	0	0	0	0	0
Criteria	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
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Families and residents are provided with information on admission which includes information about the Health and Disability Commissioner’s (HDC) Code of Health and Disability Consumers’ Rights (the Code). Staff receive training about resident rights at orientation and as part of the education programme. Interviews with two managers (nurse manager, general manager) and eleven staff (three caregivers, three registered nurses (RNs), one kitchen manager, one grounds and property supervisor, one laundry/housekeeper, one activities coordinator, one cultural advisor) reflected their understanding of the Code with examples provided of how the Code is applicable to their job role and responsibilities. Seven residents and two relatives interviewed confirmed that staff respect their privacy and support residents in making choices.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices</p>	FA	<p>There are established informed consent policies/procedures and advanced directives. General written consents are included in the admission agreement. Specific consents are obtained for specific procedures such as influenza vaccine. All six resident files including the respite resident contained signed admission agreements.</p> <p>Resuscitation status had been signed appropriately on the ‘order for life sustaining treatment’ form, which includes advance directives, and identifies the resident’s wishes for end-of-life care, including hospitalisation. Copies of enduring power of attorney (EPOA) where available were in the residents’</p>

<p>and give informed consent.</p>		<p>files.</p> <p>An informed consent policy is implemented. Systems are in place to ensure residents, and where appropriate their family/whānau, are provided with appropriate information to make informed choices and informed decisions. The caregivers interviewed demonstrated a good understanding in relation to informed consent and informed consent processes.</p> <p>Residents and relatives interviewed, confirmed they have been made aware of and fully understand informed consent processes and that appropriate information had been provided.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>Residents interviewed confirmed they are aware of their right to access independent advocacy services. Discussions with relatives confirmed the service provided opportunities for the family/enduring power of attorney (EPOA) to be involved in decisions. The resident files include information on resident's family/whānau and chosen social networks. A chaplain (interviewed) is employed 20 hours per week by PSSC and is available to speak with residents in an advocacy role.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. The activities programme includes opportunities to attend events outside of the facility. Residents are supported and encouraged to remain involved in the community with examples provided. Relatives and friends are encouraged to be involved with the service and care. Approximately 30 volunteers assist with activities, entertainment and outings.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are made available at reception, next to a suggestions box. Information about complaints is also provided on admission. Interviews with residents and families confirmed their understanding of the complaints process. The nurse manager and the general manager are able to describe the process around reporting complaints, which complies with requirements set forth by the Health and Disability Commissioner (HDC).</p> <p>There is a complaint register available. Two complaints were registered in 2020 and no complaints have been lodged in 2021 (year-to-date). Both complaints were reviewed in detail. They reflected evidence of acknowledgement, an investigation and communication with the complainant within the timeframes determined by HDC. Both complaints have been documented as closed/resolved. The complaints process is linked to quality and risk management processes.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>There is an information pack given to prospective residents and families that includes information about the Code and their right to make a complaint. There is the opportunity to discuss aspects of the Code during the admission process. Residents and relatives interviewed confirmed that information is provided to them about the Code. A large print poster explaining the Code is displayed in a visible location. The nurse manager discusses the information pack with residents/relatives on admission. Families and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>A tour of the premises confirmed there are areas that support personal privacy for residents. Resident rooms are large with ample room for visitors. Staff were observed to be respectful of residents' privacy by knocking on doors prior to entering resident rooms and speaking to residents in a respectful manner. Staff could describe definitions around abuse and neglect. Residents and relatives interviewed confirmed that staff treat residents with respect.</p> <p>The service philosophy, centred on the Eden Alternative Philosophy of Care, promotes quality of life and involves residents in decisions about their care. Resident preferences are identified during the admission and care planning process and include family involvement. Interviews with residents and family confirmed their values and beliefs are considered. This was also evidenced in the residents' files reviewed. Caregivers interviewed described how choice is incorporated into resident cares.</p>
<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	<p>One Presbyterian Support South Canterbury (PSSC) board member identifies with the Ngai Tahu iwi. A cultural advisor is employed eight hours per week for the PSSC organisation and additional links are established with Arowhenua whānau services in Temuka. A cultural competency framework is being implemented and 2020 was a year of preparing the foundations for a PSSC cultural journey with a focus on developing meaningful relationships with iwi, hapu and tangata whenua organisations within the South Canterbury communities. Work is currently underway to achieve the level one (kete) initiative with the intent of increasing cultural awareness and exploring equity and barriers to health equity with staff. This initiative is being led by the cultural advisor who was interviewed. A cultural message is regularly published in the PSSC support report newsletter.</p> <p>Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. Cultural needs are assessed during the admission process and are addressed in the care plan. There were two residents who identified as Māori at the time of the audit. One of the residents welcomed the auditors with a whakatau greeting. He also offers a karakia during the midday</p>

		meal. This resident was interviewed and confirmed that his values and beliefs were being met by the service with examples provided. He regularly visits the local marae.
<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	An initial care planning meeting is carried out where the resident and/or whānau as appropriate are invited to be involved. Individual beliefs or values are discussed and incorporated into the care plan. Six-monthly multidisciplinary team meetings assess if needs are being met. Family are invited to attend. Discussions with residents and relatives confirmed that residents' values and beliefs are considered.
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	Staff job descriptions include responsibilities. Staff meetings, newsletters and staff education and training include discussions around professional boundaries. Meeting minutes are shared with all staff with a copy of the minutes held in the staff room. Interviews with the managers and care staff confirmed their awareness of professional boundaries.
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	CI	<p>This small, purpose built, rest home is well supported by the local community which has been involved since its inception. The staff are mainly local people who work to make a difference in the residents' lives, in line with the Eden Alternative Philosophy of Care. All ten Eden principles have been attained. This continues to be a strength of the home and empowers the residents to live their best lives by ensuring decision-making is as close to the residents as possible. At the time of the audit, the focus was the residents' interests in music and gardening.</p> <p>The service benchmarks with other Presbyterian Support organisations (Presbyterian Support Otago and Presbyterian Support Southland) to improve resident outcomes. An in-service education programme is implemented as per the training plan. Staff attend a minimum of one study day per year (seven hours) where mandatory training is offered in addition to other topics. In addition, various in-services are offered throughout the year. The RNs also attend external DHB training and RN specific study days.</p> <p>There is a minimum of one first aid trained staff on each shift. Residents and family advised that the RNs and caregivers are caring and competent. A general practitioner (GP) is available twice per week.</p> <p>Quality initiatives have been implemented to address health promotion for the residents, food delivery and staff communication. This has resulted in a rating of continuous improvement.</p>

<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>There is an accident/incident reporting policy to guide staff in their responsibility around open disclosure. Staff are required to record family notification when entering an incident into the electronic (VCare) system. All 15 incident/accident reports reviewed met this requirement. Families interviewed confirmed they are notified following a change of health status and/or accident/incident of their family member. There is an interpreter policy in place and contact details of interpreters are available. At the time of the audit, all residents spoke fluent English.</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>Wallingford Rest Home is part of the PSSC organisation and provides care for up to 32 rest home level residents. Two beds are permanently allocated for respite residents. At the time of the audit there were 31 rest home residents, which included one resident on respite care. All other residents were under the aged related residential care (ARRC) contract.</p> <p>The nurse manager is a registered nurse and maintains an annual practising certificate. She has been in this role for ten years and has worked in aged care for 18 years. The nurse manager is supported by three RNs, care staff and the PSSC management team including the general manager for services for older people and the chief executive officer (CEO).</p> <p>The organisation has a philosophy of care which includes a mission statement. The developed strategic plan (2017-2027) includes aged care as one of nine business strategies. There is an organisational quality plan (2019-2021) with specific quality objectives. The Eden Alternative philosophy of care is an important part of the organisation, which is understood and implemented by all members of the organisation including the Board.</p> <p>The nurse manager has completed in excess of eight hours of professional development over the past year pertaining to the management of an aged care facility.</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</p>	<p>FA</p>	<p>In the absence of the nurse manager, an RN (second in charge) has been appointed to take over the role of nurse manager with support from the administration/care manager, and PSSC senior management team.</p>

consumers.		
<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>	FA	<p>The quality and risk management programme is designed to monitor contractual and standards compliance. Discussions with the nurse manager and staff reflected their involvement in quality and risk management processes.</p> <p>The services policies are reviewed at organisational level every two years. Staff have access to the policy manuals. Internal audits are completed as per the quality activities planner 2020–2021. Corrective actions are implemented and signed off where opportunities for improvements are identified. Staff are kept informed.</p> <p>Data is collected (e.g., behaviours of concern, falls, skin tears, pressure injuries facility-acquired, medication errors, urinary tract infections, skin infections, respiratory tract infections) and trends are analysed. Data is benchmarked monthly against other Presbyterian Support (Presbyterian Support Otago, South Canterbury and Southland) facilities at a rest home level of care. Quality data is discussed in meeting minutes (e.g., CQI meetings, staff meetings). Meeting minutes are available for staff to read in the staffroom. Data is also posted in the staffroom. Interviews with caregivers and RNs confirmed that they are kept informed. Areas of non-compliance identified through quality activities are actioned for improvement as quality improvement projects with examples provided (e.g., health education for residents, daily morning circles for staff, extra RN help following lockdown to cover for the large number of residents' appointments at Timaru Public Hospital). Resident/relative meetings are held every six-weeks to eight weekly.</p> <p>There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. The health and safety plan (July 2019 – June 2021) describes the health and safety programme. The grounds and property supervisor is the health and safety officer (interviewed). A health and well-being calendar is being implemented. Routine monitoring of the facility is undertaken to check for any increased risks from environmental hazards. Health and safety meetings take place three monthly. All health and safety representatives have completed level one health and safety training. Hazards are entered on the hazard register if they cannot be eliminated.</p> <p>Falls prevention strategies are in place including (but not limited to): sensor mats, increased monitoring for those residents at high risk of falling, and the identification and meeting of individual resident needs. A physiotherapist is on site 1.5 hours per week.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p>	FA	<p>There is an incident/accident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring, corrective actions to minimise and debriefing. Individual incident/accident reports are completed for each incident/accident with immediate action</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>noted and any follow-up action required.</p> <p>A review of 15 incident/accident forms (challenging behaviours, medication errors, unwitnessed falls) identified that the incident/accident forms are fully completed electronically on VCare and include follow-up by a registered nurse. The nurse manager signs off each incident/accident report. Neurological observations are completed for unwitnessed falls using an assessment tool developed by the Red Cross. Vital signs are initially recorded followed by visual checks that are completed by the caregivers: half-hourly for one hour, hourly for four hours and then four hourly for 24 hours.</p> <p>The nurse manager is able to identify situations that would be reported to statutory authorities. There have been no outbreaks since the previous audit. One Section 31 report was planned to be completed for a resident who had absconded.</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>Human resources policies include recruitment, selection, orientation and staff training and development. Six staff files reviewed (one RN, three caregivers, one diversional therapist, one housekeeper) reflected evidence of reference checking, signed employment contracts and job descriptions, and completed orientation programmes. Orientation is specific to the individual's job role and responsibilities.</p> <p>An updated process for performance appraisals is underway with staff completing a self-evaluation prior to the manager providing additional feedback. In the six staff files reviewed, all performance appraisals were up-to-date.</p> <p>Current registered nursing staff and external health professionals (general practitioners, physiotherapist, pharmacists, podiatrist) practising certificates were sighted.</p> <p>There is an implemented annual education and training plan that exceeds eight hours annually per staff member. Staff are scheduled for a minimum of one study day per year (seven hours) which covers a full range of topics including a refresher on the Eden Philosophy. Annual competency assessments are completed for a range of topics including but not limited to infection control, medication, and code of care/complaints/informed consent. A register for each training session and an individual staff member record of training was verified. The nurse manager and registered nurses attend external training including conferences, seminars and sessions provided by PSSC.</p> <p>Registered nurses are supported to maintain their practising certificate. Two of four registered nurses (including the nurse manager) have completed their interRAI training. Nineteen caregivers are employed. Two have completed a Careerforce level four qualification with two studying for level four; and seven have completed a level three qualification with three studying for level three.</p>

<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>PSSC policy includes a rationale for staff rostering and skill mix. Sufficient staff are rostered on to manage the care requirements of the residents. A staff availability list ensures that staff sickness and vacant shifts are covered. The nurse manager (who maintains her practising certificate) and RNs are available on call 24/7 for any emergency issues or clinical support.</p> <p>There were 31 residents at the time of the audit. There is one RN available on site on the AM shift and three caregivers (two long and one short shift to 1230); three caregivers (two long and one short shift 1630 – 2130) are rostered on the PM shift; and two caregivers are rostered on the night shift.</p> <p>Interviews with staff, residents and families identified that staffing is adequate to meet the needs of residents. Two RNs are available one day a week for assistance with paperwork (e.g., interRAI) and GP rounds.</p> <p>Staff are visible and attend to call bells in a timely manner as confirmed by all resident and relatives interviewed. Staff interviewed stated that overall, the staffing levels are satisfactory and that the nurse manager provides good support. Residents and relatives interviewed reported there are sufficient staff numbers.</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 were 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. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are held electronically using VCare. They are protected from unauthorised access. Entries are computerised, dated and include the relevant caregiver or nurse including their designation. Individual resident files demonstrate service integration.</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>Entry to services is centralised through the resident liaison manager who coordinates all admissions to PSSC facilities in conjunction with nurse managers. All residents are assessed by the needs assessment service coordination centre (NASC).</p> <p>Admission information packs include information about the facility, information such as the Code, advocacy and the complaints procedure. Information is provided for families and residents prior to admission or on entry to the service. All admission agreements reviewed (for long-term and the respite residents) aligned with all contractual requirements. Exclusions from the service are included in the admission agreement. Relatives interviewed agreed that admission to services was well managed.</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 are coordinated in collaboration with the resident and relatives to ensure continuity of care. There are documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. The service utilises the 'yellow envelope' system when transferring residents to the hospital. The registered nurses interviewed could easily describe the transfer and discharge processes.</p> <p>The residents and their families are 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. The RNs and senior caregivers who administer medications complete annual medication competencies. Annual in-service education on medication is provided by the supplying pharmacist. Medications (blister packs) are checked on delivery against the medication chart and any discrepancies fed back to the pharmacy. All medications are stored safely in the treatment room. Standing orders are not used. The temperature of the clinic room and medication fridge are monitored daily and were within acceptable ranges. All eye drops, and creams were dated on opening.</p> <p>Ten electronic medication charts were reviewed. All medication charts had photo identification and an allergy status. The GP reviews the medication charts at least three-monthly. Prescribed 'as required' medications include the indication for use. There were no residents self-administering. Pain assessment and effectiveness is documented on the medication system. The medication system is used to record a range of observations including (but not limited to) resident weight, and blood sugar recordings. There are messages between the pharmacy, facility and GP practice regarding ordering of medications and INR (Warfarin) recordings and dosage. The GP interviewed was positive around the effectiveness of the use of the electronic medication system.</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 and home baking is prepared and cooked on site by experienced and/or qualified cooks. There is a food control plan which expires on 21 September 2021. There is a four-week seasonal menu in place which is reviewed annually by the dietitian. The dietitian is contracted to provide services for PSSC. The dietitian visits each facility monthly to review residents of concern. The dietitian has recently reviewed the nutrition and hydration policies to be in line with the dietitian standards. Food services is overseen by the PSSC food services manager.</p> <p>The cook is informed of resident dietary needs and changes. Likes and dislikes are accommodated. Additional or modified foods such as soft foods, pureed and meat free meals are provided. Annual resident satisfaction surveys occur annually and include aspects of the food service.</p> <p>All meals are prepared in the kitchen adjacent to the dining room, plated and served directly to the</p>

		<p>residents. The buffet service was stopped due to Covid-19 regulations. Staff inform the residents of choices, and the residents now choose what they would like, and the meal is plated for them from the portable bain marie at their tables or in their rooms. Residents choose their dessert from the dessert trolley.</p> <p>Fridge and freezer temperatures are monitored and recorded daily. End-cooked temperatures are taken twice daily. All containers of food stored in the pantry are labelled and dated. All perishable goods are date labelled. A cleaning schedule is maintained. Residents with weight loss are provided with food supplements. Residents and relatives interviewed spoke positively about the meals provided (link 1.1.8.1).</p>
<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	<p>Declining services is also managed by the resident liaison manager. 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. The service communicates directly with the referring agencies and family/whānau as appropriate if entry was declined.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>An RN completes a comprehensive initial assessment and care plan on admission, including a clinical risk assessment and relevant risk assessment tools. A suite of assessments is available on the electronic resident management system. Risk assessments are completed six-monthly with the interRAI assessment or earlier due to health changes. InterRAI assessments reviewed were completed within 21 days of admission and at least six-monthly thereafter.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Electronic resident care plans reviewed were overall resident focused. Short-term care plans are used for changes to health status and were sighted in resident files, for example, infections, post falls, and changes in medications. Long-term care plans evidenced resident and family involvement in the care plan process. Relatives interviewed confirmed they were involved in the care planning process. Resident files demonstrated service integration. The respite resident had interventions documented in the care plan that were appropriate to their needs, this resident interviewed also complimented the care.</p> <p>Staff interviewed identified a high level of resident knowledge by caregivers and leadership by the RN team.</p>

		There was evidence of allied health care professionals involved in the care of the resident including the physiotherapist, podiatrist and the dietitian.
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Discussion with staff and observation, evidenced that service interventions were caring and supportive. When a resident's condition alters, a registered nurse initiates a review and if required, GP or nurse practitioner consultation. There is documented evidence on the electronic files that indicates family members were notified of any changes to their relative's health. Discussions with relatives confirmed they are notified promptly of any changes to their relative's health.</p> <p>Adequate dressing supplies were sighted in the treatment room. Wound management policies and procedures are in place. Electronic wound assessment and treatment forms, ongoing evaluation form and evaluation notes were in place for a resident with wounds. There were eight wounds (three skin tears, one skin split, one donor site, one graft site and two chronic ulcers).</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified. There is access to a continence nurse specialist by referral.</p> <p>Residents are weighed monthly or more frequently if weight is of concern. A suite of electronic monitoring forms is available. Monitoring forms in use included (but not limited to) weight, vital signs, and blood sugar levels, 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>	CI	<p>The three activities staff provide an activities programme over six days each week. The activities coordinator (diversional therapist) works Monday to Friday. One activities assistant works on a Wednesday and another works on a Thursday (to relieve the activities coordinator to catch up with documentation).</p> <p>The programme is planned weekly with resident input provided through the 'catch up with Sandy' Monday meetings. Residents receive a personal copy of planned weekly activities. Activities planned for the day are displayed on noticeboards around the facility.</p> <p>An activity plan is developed for each individual resident, based on assessed needs and is part of the long-term care plan. Activity plans were reviewed three to six-monthly in files sampled. Electronic activity progress notes are maintained. Wallingford implements the Eden Alternative which is aimed at reducing loneliness, helplessness and boredom, these are discussed with residents and resident goals are set around reducing these. Goals are reviewed at least six-monthly or when the resident chooses to change or add to their goal.</p>

		<p>Residents are encouraged to join in activities that are appropriate and meaningful and are encouraged to participate in community activities.</p> <p>Groups are invited to participate in the Wallingford Rest Home programme including pre-school, primary and high school children. Families are actively involved in the service and pets are encouraged. The service has a van that is used for resident outings. The residents and children from the local kindy have turns around visiting each other. Residents are supported to access the community as they wish on their mobility scooters.</p> <p>The service has 16 registered volunteers that assist with the activity programme. Regular volunteers assist with the shopping trolley, perform hospital visits, drive the van, assist residents at election time and read novels to the residents.</p> <p>Residents were observed participating in activities on the day of audit. Resident meetings provide a forum for feedback relating to activities. Residents and relatives interviewed discussed enjoyment in the programme and the diversity offered to all residents. The service has exceeded the required outcome around activities.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>All initial care plans for long-term residents were evaluated by an RN within three weeks of admission and long-term care plans developed. Long-term care plans have been evaluated by an RN six-monthly, using the interRAI tool or earlier for any health changes for files reviewed. 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 or the care plan. Short term care plans are reviewed regularly and either resolved or added to the long-term care plan.</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>	FA	<p>Referral to other health and disability services is evident in the residents' files sampled. The registered nurses facilitate access to other medical and non-medical services. Referral documentation is maintained on residents' files and was sighted for the dietitian, district nursing, psychogeriatric nurse, and eye specialist. Referrals to medical specialist are made by the GP.</p> <p>There are documented policies and procedures in relation to exit, transfer or transition of residents. The residents and the relatives are kept informed of the referrals made by the service.</p>
<p>Standard 1.4.1: Management Of</p>	FA	<p>There are documented policies around waste management. There is a locked designated chemical</p>

<p>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>cupboard for storage of cleaning/laundry chemicals and chemicals. All chemicals are labelled with manufacturer labels.</p> <p>Product use charts were available, and the hazard register identifies hazardous substances. Gloves, aprons, and goggles are available for staff. Safe chemical handling training has been provided. Staff interviewed were knowledgeable around the management of waste.</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>	FA	<p>The service displays a current building warrant of fitness which expires on 1 June 2021. Hot water temperatures are checked monthly. Medical equipment and electrical appliances have been tested and tagged and calibrated annually. Regular and reactive maintenance occurs. Residents were observed to mobilise safely within the facility. There are sufficient seating areas throughout the facility. The exterior has been well maintained with safe paving, outdoor shaded seating, lawn and gardens; the internal courtyard has a small aviary. Caregivers interviewed confirmed there was adequate equipment to carry out the cares according to the resident needs as identified in the care plans. A maintenance book is used to record breakages. The maintenance team are located in Timaru and visit the facility twice weekly, or more often if required.</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 Wallingford are single rooms with individual or shared ensuites (six rooms do not share ensuites). Residents interviewed stated their privacy and dignity is maintained while attending to their personal cares and hygiene.</p> <p>There are sufficient numbers of resident communal toilets in close proximity to resident rooms and communal areas. Visitor toilet facilities are available. The communal toilets are well signed and identifiable and include vacant/in-use signs.</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 and fully furnished. Each resident room has individual furnishings and décor. There is adequate room for residents to safely manoeuvre using mobility aids. Residents and families are encouraged to personalise their rooms as viewed on the day of audit. Caregivers interviewed reported that rooms have sufficient space to allow cares to take place.</p>

<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>There is a large main lounge, a large spacious dining room, and two smaller lounges for residents and relatives to use as they wish. Activities take place in any of the lounges. The furnishings and seating are appropriate for the consumer group. All areas are easily accessible for the residents.</p> <p>The dining room is light and spacious and located directly off the kitchen/servery area.</p> <p>Residents interviewed reported they are able to move around the facility and staff assisted them when 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>	FA	<p>There are adequate policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. All linen and personal clothing is laundered on site. There is a designated laundry assistant/housekeeper employed seven days a week. The laundry has two commercial washing machines and dryers. There are clearly defined clean/dirty areas. The effectiveness of the cleaning and laundry processes are monitored through internal audits, resident meetings and surveys. The laundry assistant/housekeeper interviewed was knowledgeable around infection control practices and has attended chemical training.</p> <p>Cleaning trolleys are stored safely when not in use. Residents and relatives interviewed were satisfied with the laundry service and cleanliness of the communal areas and their bedrooms.</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>	FA	<p>There is at least one staff member on duty at all times with a first aid certificate including during outings. Emergency preparedness plans are accessible to staff and include the management of potential emergency situations. The service has civil defence resources and supplies including alternative heating and cooking facilities (BBQ and gas bottle). Battery back-up for emergency lighting is available for up to four hours. Extra water (ten litres per person per day) and food stores are available for a minimum of three days. There are sufficient first aid and dressing supplies available. The service has an approved fire evacuation scheme. Fire evacuation training and drills are conducted six-monthly.</p> <p>Call bells are situated in all communal areas, toilets, bathrooms and personal bedrooms. Residents were sighted to have call bells within reach during the audit. Visitor's sign-in/out at reception including contractors. Security checks are conducted each night by staff and an external agency.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p>	FA	<p>Residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. Underfloor heating is provided throughout the</p>

<p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>		<p>facility. Room temperatures can be individually adjusted. All bedrooms have adequate natural light.</p>
<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>	<p>FA</p>	<p>The PSSC organisation has an established infection control programme which considers the Eden philosophy, and is implemented in Wallingford. There is a designated infection control nurse for PSSC. The infection control nurse is a senior registered nurse and has been in the role since February 2020.</p> <p>The infection control programme, its content and detail is appropriate for the size, complexity and degree of risk associated with the service. The infection control programme is linked into the incident reporting system and logged onto the benchmarking programme quarterly. Regular audits take place that include hand hygiene, infection control practices, laundry and cleaning.</p> <p>Three monthly meetings are held by the infection control committee. Feedback from the meetings is given to staff via the RN and facility meetings, minutes are available to staff. Annual education is provided for all staff at the residential study days. Infection control data is included in the staff newsletter.</p> <p>Visitors are reminded not to visit the facility if they are feeling unwell. Each visitor/contractor is required to complete a wellness declaration on entering the facility in line with current Covid-19 guidelines. Extra hand sanitiser stations have been installed around the facility.</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>	<p>FA</p>	<p>There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The infection control nurse maintains practice by completing online infection control training, maintaining membership of the New Zealand Nurses Organisation (NZNO) infection control group. The infection control coordinator has access to Lippincott, the public health nurse, the DHB infection control specialist and the microbiologist.</p> <p>The infection control committee comprises of one to two representatives from each facility and the community services. Staff interviewed were knowledgeable around infection control practices. The flu vaccine and Covid vaccines are available to staff and residents.</p> <p>Covid-19 was well prepared for, policies, procedures and the pandemic plan were reviewed to include Covid-19. There were no findings or recommendations following the Covid-19 DHB audit. Staff and relatives were regularly updated via emails and phone calls. Residents were updated regularly. Competencies were held around donning and doffing personal protective equipment, handwashing and isolation procedures. Adequate supplies of personal protective equipment were sighted throughout the</p>

		audit and weekly stocktakes are maintained.
<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 policy and procedures for PSSC that are appropriate to 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 are developed by the organisation and reviewed and updated annually and have been reviewed to include Covid-19.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>Presbyterian Support South Canterbury is committed to the ongoing education of staff and residents. The infection control coordinator has completed infection control training. Formal infection control education for staff has occurred. Information is provided to residents and visitors that is appropriate to their needs and this is documented in the electronic resident files.</p> <p>Infection control education is provided at the compulsory residential study days. The infection control coordinator has developed the competencies for all staff including orientation and has reviewed and changed the internal audits around flu vaccines and hand hygiene. The infection control committee is representative of the organisation. The committee monitors attendance, and feedback is analysed to develop new areas of interest.</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>	FA	<p>Infection surveillance is an integral part of the infection control programme and is described in PSSCs infection control manual. Monthly infection data is collected for all infections based on the antibiotic usage prescribed on the electronic medication system. Individual resident infections are recorded on the electronic resident file system. Short-term care plans are used for residents with infections. Surveillance of all infections are entered onto a monthly infection summary. This data is monitored and evaluated monthly, quarterly and annually and provided to the general manager - services for older people, who collates all facilities statistics and produces graphs of data for internal benchmarking. PSSC have commenced benchmarking with sister Presbyterian support services.</p>

		Outcomes and actions are discussed at all facility and staff meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the nurse manager. There have been no outbreaks since the previous audit.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	<p>The service has documented systems in place to ensure the use of restraint is actively minimised. There were no residents with restraints or enablers at the time of the audit. Staff interviews, and staff records evidenced guidance has been given on restraint minimisation and safe practice. Policies and procedures include definitions of restraint and enabler that are congruent with the definition in NZS 8134.0.</p> <p>Restraint and enabler use is discussed at the PSSC CQI committee meetings. The PSSC general manager (RN) is the designated restraint coordinator for Wallingford Rest Home. Staff attend training around restraint minimisation and enablers, falls prevention and management of challenging behaviours.</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.

No data to display

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	The service provides an environment that encourages good practice, which is beyond the expected full attainment.	<p>The service has conducted a number of quality improvement projects where a review process has occurred, including analysis and reporting of findings. There is evidence of actions taken that have resulted in improvements to service provision. The projects include reviewing if the improvements have had positive impact on residents’ safety or residents’ satisfaction. Examples include the following:</p> <p>Residents have attended two health promotion seminars, delivered by specialists from the South Canterbury DHB, to help improve their health outcomes. Topics have covered skin management (15 attendees) and urinary tract infections (13 attendees). A future in-service is planned to address breast and prostate cancer as per requests by the residents. Residents interviewed confirmed that these training sessions were valuable, and they look forward to future ones.</p> <p>Following suspending the buffet meal service during lockdown, a challenge was to facilitate a way that the residents could still choose what they ate and how much they ate while not actually serving themselves. A portable bain marie was purchased so that it can be taken to each table in turn so that residents can choose what they want, and staff can serve it directly to them. Food satisfaction scores (July 2020) are above the PSSC benchmark with residents responding to the query ‘the meal service provided is of a high</p>

			<p>standard' with a response rate of 95% satisfaction (17 of 29 surveys were returned).</p> <p>Staff attend daily morning learning circle meetings. These have been implemented due to the fact that none of the shift hours overlap and as a result, gaps in communication were occurring, especially on the morning shift. This short meeting takes place straight after the resident's breakfast and staff have the time to discuss the flow for the day.</p>
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	CI	<p>The service continues to enhance and support residents to have quality of life in line with the Eden model. There is continued resident input and good attendance at activities.</p>	<p>During the 2020 level four lockdown period, the residents decided they missed the visiting entertainers who played music and wanted to introduce music to the facility. During this time the residents decided to set up a choir, they sang to the volunteers on their return to the facility once the lockdown levels were reduced. Since then, the choir has been approached to sing at Christmas functions for the local Probus and church groups. The choir (witnessed practicing during the audit) are now in the process of developing a mid-winter theme for their next performance.</p> <p>The residents continue to enjoy inter-home competitions throughout the region and organised a bowls tournament where nine rest home teams competed for a cup. Bowls are run by volunteers.</p> <p>The Wallingford calendar was made and included photos of residents throughout the year, (consent was gained) this was sent to relatives all over the world.</p> <p>The service participates in the 'respect' programme. This includes children from the local catholic church kapa haka group, and other local schools visiting the facility. The children teach the residents about technology, and in return, the residents teach the children how to play games such as bowls. This has been successful in building intergenerational relationships.</p> <p>The residents and relatives all spoke very highly around the activity programme, their involvement and were proud when their suggestion was implemented.</p>

End of the report.