

Presbyterian Support Services Otago Incorporated - Taieri Court 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 Otago Incorporated

Premises audited: Taieri Court Rest Home

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 10 June 2021 End date: 11 June 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: 33



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

Taieri Court is part of the Presbyterian Support Services Otago group of aged care facilities. The facility has a total of 33 beds suitable for rest home level care. On the day of audit there were 33 residents. All residents were funded through the Age-Related Residential Care Agreement (ARRC).

This certification audit was conducted against the relevant Health and Disability standards and the contract with the district health board. The audit process included a review of policies and procedures, the review of residents' and staff files, observations and interviews with residents, relatives, staff, management and general practitioner.

The nurse manager is a registered nurse who has been in this role for over 15 years. She is very experienced in both elderly care and management. The nurse manager is supported by a registered nurse and experienced care staff. Support from the central office includes a quality advisor and clinical nurse advisor and the director enliven services.

There are well-developed systems, processes, policies and procedures that are structured to provide appropriate quality care for people who use the service, including residents that require rest home level care. Implementation is supported through the PSO quality and risk management programme that is individualised to Taieri.

A comprehensive orientation and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support, is in place.

This audit identified one area requiring improvement around staff appraisals. The service has been awarded two 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 complies with the Health and Disability Commissioner's Code of Health and Disability Consumers' Rights. Staff strive to ensure that care is provided that focuses on the individual resident, values residents' autonomy and maintains their privacy and choice. Cultural needs of residents are met. Policies are implemented to support residents' rights, communication and complaints management. Information on informed consent is included in the admission agreement and discussed with residents and relatives. 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.		Some standards applicable to this service partially attained and of low risk.
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The nurse manager is supported by a registered nurse, care workers and support staff. The quality and risk management programme includes a service philosophy, goals and a quality and risk management programme. Quality activities generate improvements in practice and service delivery. Meetings are held to discuss quality and risk management processes and results. Resident and family meetings are held, and satisfaction is monitored via annual satisfaction surveys. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and investigated. A comprehensive education and training programme is implemented with a current plan in place. Appropriate employment processes are adhered to. There is a roster that provides sufficient and appropriate staff cover 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.		All standards applicable to this service fully attained with some standards exceeded.
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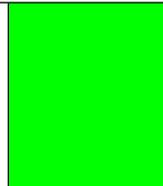
Prior to entry to the service, residents are screened and approved. The service's nurse manager and registered nurse, who also have the responsibility for maintaining and reviewing the support plans, develop the long-term care plans.

InterRAI assessment tools and monitoring forms are used to assess the level of risk and ongoing support required for residents. Care plans are evaluated six monthly or more frequently when clinically indicated. The service facilitates access to other medical and non-medical services. The activity programme is varied and reflects the interests of the residents and includes outings and community involvement.

Medication policies reflect legislative requirements and guidelines. Staff responsible for the administration of medicines complete annual education and medication competencies. All meals are prepared on site. Individual and special dietary needs are catered, and alternative options are available for residents with dislikes. A dietitian has designed and reviewed the menu. Regular audits of the kitchen occur.

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.

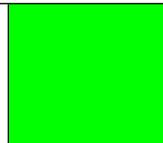


Standards applicable to this service fully attained.

The service has implemented policies and procedures for fire, civil defence and other emergencies. The building warrant of fitness has been extended by one year in May 2021. Rooms were individualised. External areas were safe and well maintained. The facility has a van available for transportation of residents. There was a main lounge, two smaller lounges and a separate dining room. There were adequate communal toilets and showers. Fixtures, fittings and flooring are appropriate for rest home level care. Communal laundry is laundered off site at a commercial laundry. Cleaning and all laundry services were well monitored through the internal auditing system. Chemicals are stored securely. The temperature of the facility was comfortable and constant, and able to be adjusted in resident's rooms to suit individual resident preference.

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.

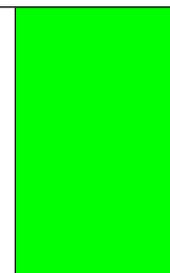


Standards applicable to this service fully attained.

Restraint minimisation and safe practice policies and procedures are in place. Staff receive training in restraint minimisation and challenging behaviour management. On the day of audit there were no residents using restraint and no residents with an enabler.

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 implemented and meets the needs of the organisation and provides information and resources to inform the service providers. There are Covid-19 alert level management plans in place and sufficient PPE is on hand. Documented policies and procedures are in place for the prevention and control of infection and reflect current accepted good practice and legislative requirements. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. 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)
Standards	2	42	0	1	0	0	0
Criteria	2	90	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)
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>The Health and Disability Commissioner’s (HDC) Code of Health and Disability Consumers’ Rights (the Code) policy and procedure is implemented. Discussions with the nurse manager, quality advisor, clinical nurse advisor and nine staff (four caregivers who cover morning and afternoon shifts, a registered nurse (RN), one activities coordinator, one administrator, one kitchen manager and one property manager) confirmed their familiarity with the Code. Interviews with four residents and four relatives confirmed that the services being provided are in line with the Code. Staff receive training on the Code, last occurring in March 2021.</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 and give informed consent.</p>	FA	<p>The service has policies and procedures relating to informed consent and resuscitation directives. All six resident files reviewed included signed informed consent forms and advance directive instructions. The resident or nominated representative signed admission agreements (sighted). Discussion with residents and families identified that the service actively involves them in decision-making.</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>	FA	<p>There is a policy that describes the role of advocacy services. Staff receive annual training on advocacy. Information about accessing advocacy services is available in the information presented to residents and their families during entry to the service. Advocacy support is available if requested. Interviews with staff, residents and relatives confirmed that they were aware of advocacy services and how to access an advocate. The complaints process reminds the complainant of their right to contact the Health and Disability Advocacy Service with contact details provided.</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>	FA	<p>Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. Activities programmes include opportunities to attend events outside of the facility including activities of daily living, (e.g., attending cafés and restaurants). Interviews with staff, residents and relatives informed residents are supported and encouraged to remain involved in the community and external groups. Relatives and friends are encouraged to be involved with the service and care.</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>	FA	<p>The complaints policy describes the management of the complaints process. Complaints forms are available. Information about complaints is provided on admission. Interviews with residents and families demonstrated their understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints.</p> <p>There is a complaint register. There have been no complaints since the last surveillance audit.</p> <p>Complaints are linked to the quality and risk management system. Discussions with residents and relatives confirmed that any issues are addressed and that they feel comfortable to bring up any concerns.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>There are posters displaying the Code in English and in Māori. The service is able to provide information in different languages and/or in large print if requested. On entry to the service, the nurse manager or registered nurse discuss the Code with the resident and the family/whānau. An information pack is given to the resident, next of kin or enduring power of attorney (EPOA) to read and discuss. Residents and relatives interviewed identified they are well informed about the Code of Rights. Monthly resident meetings provide the opportunity to raise concerns. An annual residents/relatives survey is completed.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And</p>	FA	<p>Taieri Court has policies which align with requirements of the Privacy Act and Health Information Privacy Code. During the audit, staff demonstrated gaining permission prior to entering residents' rooms. All</p>

<p>Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>		<p>care staff interviewed demonstrated an understanding of privacy and could describe how choice is incorporated into residents' care. Residents and family members interviewed confirmed that staff promote the residents' independence wherever possible, and that residents' choices are encouraged. There is an abuse and neglect policy that is implemented. Staff education and training on abuse and neglect has been provided, last occurring in October 2020.</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>	<p>FA</p>	<p>The service has established Māori cultural policies that were developed with the combined Te Runanga o Otakou [Inc]. The policies provide recognition of Māori values and beliefs and identify culturally safe practices for Māori.</p> <p>Best practice policies and procedures are available to staff and specialist advice is sought, when necessary, from the local iwi; Aukaha (local branch of the kaitahu iwi). Members from Aukaha are able to provide cultural supervision and initial train the trainer.</p> <p>A cultural assessment is completed during the Māori resident's entry to the service. There were no residents who identified as Māori.</p>
<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>	<p>FA</p>	<p>The service has established cultural policies aimed at helping to meet the cultural needs of its residents. All residents and relatives interviewed reported that they were satisfied that the residents' cultural and individual values were being met. Information gathered during assessment, including residents' cultural beliefs and values, is used to develop a care plan. The resident (if appropriate) and/or their family/whānau are asked to consult on the care plan. Discussions with staff confirmed that they are aware of the need to respond to the cultural needs of the residents. All of the residents were able to speak and understand English.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Staff job descriptions include responsibilities and staff sign a copy on employment. The quality meetings occur monthly and include discussions on professional boundaries and concerns as they arise. Professional boundaries are reconfirmed through education and training sessions, at handover meetings, and performance management if there is infringement with the person concerned. Interviews with all staff confirmed an awareness of professional boundaries including the boundaries of the care workers' role and responsibilities.</p>
<p>Standard 1.1.8: Good Practice</p>	<p>CI</p>	<p>Promoting and encouraging good practice was evident during the audit. Registered nursing staff are</p>

<p>Consumers receive services of an appropriate standard.</p>		<p>available on call after hours and weekends. The service receives support from the district health board including visits from specialists (e.g., wound care, mental health) as well as staff education and training. Physiotherapy services are provided one day a week for four hours.</p> <p>The organisation have simplified care planning into four sections and implemented these changes within the electronic resident management system. The four sections are: getting to know me, interactive me, supporting me and healthy me. The organisation has created an electronic documentation manual which incorporates the new care planning structure and enables easy access to policies relating to documentation. The service has exceeded the standard in this area.</p> <p>There is a robust education and training programme for staff that includes in-service training, impromptu training and competency assessments. Podiatry services and hairdressing services are provided. The service has links with the local community and encourages residents to remain independent.</p>
<p>Standard 1.1.9: Communication 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 were given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alert staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. A record of family communication is indicated by a specific progress note in each resident's file.</p> <p>Twelve incidents/accidents forms selected for review indicated that family were informed. Families interviewed confirmed they are notified of any changes in their family member's health status.</p> <p>Interpreter services are available if needed. Staff and family are utilised in the first instance.</p>
<p>Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Taieri Court is part of the Presbyterian Support Services Otago (PSO) group of aged care facilities. The care facility has a total of 33 beds suitable for rest home level care. On the day of audit all beds were occupied. All residents were funded through the Age-Related Residential Care Agreement (ARRC).</p> <p>Presbyterian Support Otago has a current strategic plan, a business plan and a quality plan for 2021. There is a Taieri specific quality plan that links to the organisational plan. Taieri quality plans include: continuing to embed the Enliven philosophy, maintenance of a positive workplace environment, encourage staff attainment of Careerforce qualifications and increase resident community involvement. Achievement towards goals is included in a monthly report to the PSO quality advisor.</p> <p>The nurse manager is a registered nurse who has experience in management and aged care and has been in the role for over 15 years. She is supported by an experienced registered nurse for 32 hours a week who has been in the position for 18 months. The quality advisor and clinical nurse advisor also</p>

		support the facility manager in the management role and were present during the days of the audit. The nurse manager has maintained at least eight hours annually of professional development activities related to managing an aged care facility.
<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>	FA	In the absence of the nurse manager, the registered nurse or the PSO relieving manager takes on the role, supported by the wider PSO management team.
<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>A quality and risk management programme is in place and embedded in practice. Interviews with the managers and staff confirmed their understanding of the quality and risk management systems.</p> <p>Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. A document control system is in place. Policies are regularly reviewed. Policies and procedures include reference to interRAI for an aged care service and meet current health and safety legislative requirements. New policies or changes to policy are communicated to staff, evidenced in meeting minutes.</p> <p>Data collected (e.g., falls, medication errors, wounds, skin tears, pressure injuries, complaints, challenging behaviours) are collated and analysed with results communicated to staff. Corrective actions are implemented where benchmarked data exceeds targets. Benchmarking has recently been extended to encompass Presbyterian Support South Canterbury and Southland. In addition to this, the PSO organisation has linked benchmarking to a wider national group including most large providers of aged care in New Zealand.</p> <p>An internal audit programme is in place. In addition to scheduled monthly internal audits, six monthly wellness checks are undertaken (a PSO full audit process undertaken by the quality advisor and clinical). Areas of non-compliance include the initiation of a corrective action plan with sign-off by a manager when implemented. Quality and risk data is shared with staff via meetings and posting results in the nurse's station. Minutes of these meetings are made available to all staff. Required actions and resolutions from facility meetings are documented. Resident/relative meetings are monthly. Annual resident/relative satisfaction surveys are completed with results communicated to residents and staff.</p>

		<p>The results for the resident and relative satisfaction surveys completed in 2020 were positive in all areas with 100% satisfaction from residents in areas of respect, choice, privacy, the environment and meals.</p> <p>Presbyterian Support has a strong health and safety commitment and committees. There is a central health & safety committee that has representation from all PSO services including the eight Enliven care homes. Taieri Court has a health and safety committee that meets monthly as part of the quality meeting. All committee members have completed health and safety training. The facility manager has attended updates on health and safety procedures during manager's days in Dunedin.</p> <p>Falls prevention strategies are in place including intentional rounding, sensor mats, post falls reviews, physiotherapy reviews and individual interventions. The nurse manager reviews all falls and documents a monthly report. Care worker interviews confirmed that they are aware of which residents are at risk of falling and that this is discussed during staff handovers.</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>	FA	<p>There is an accident and incident reporting policy. Adverse events are investigated by the nurse manager and/or registered nurse, as evidenced in all twelve accident/incident forms reviewed. Adverse events are trended and analysed with results communicated to staff. There is evidence to support actions are undertaken to minimise the number of incidents. Clinical follow-up of residents is conducted by a registered nurse. Unwitnessed falls include neurological observations.</p> <p>Discussion with the facility manager confirmed her awareness of the requirement to notify relevant authorities in relation to essential notifications. Examples provided included: A section 31 for a resident assessed as psychogeriatric care who stayed at Taieri Court for an extended period of time pending availability of a bed.</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>	PA Low	<p>There are human resource management policies in place which include the recruitment and staff selection process. Relevant checks are completed to validate the individual's qualifications, experience and veracity. A register of current practising certificates is maintained. Six staff files reviewed (three care workers, one RN, one administration assistant and one activities person) reflected evidence of: reference checking, signed employment contracts, signed job descriptions and completed orientation programmes.</p> <p>Taieri Court has implemented an orientation programme that provides new staff with relevant information for safe work practice. Staff orientations were fully completed; however, three monthly post-employment reviews were not always completed as scheduled. Performance appraisals are scheduled annually, however not all have occurred. There is an implemented annual education and training plan that exceeds eight hours annually per staff member. Training is primarily held at monthly sessions and on an</p>

		<p>individual basis with competency assessments linked to training. A register for each training session and an individual staff member record of training was verified.</p> <p>Registered nurses are supported to maintain their professional competency. The nurse manager and RN have completed their interRAI training. The service encourages Careerforce qualifications for staff. There are eight care workers with level three Careerforce qualification and a further two enrolled in level three. Two care workers are enrolled in level four.</p> <p>The cook has completed a qualification in food safety and food hygiene. All kitchen staff have completed their food safety training on site. Chemical safety training is included in staff orientation and as a regular in-service topic. The RN is able to attend external training including sessions provided by the district health board.</p> <p>Current registered nursing staff and external health professionals (general practitioners, physiotherapist, pharmacists, podiatrist) practising certificates were sighted.</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>A staff rationale and skill mix policy is in place. PSO Taieri Court has a four-weekly roster in place that ensures that there are sufficient staff rostered on. The fulltime nurse manager is a registered nurse. Core care staffing was reported as stable with some staff having worked at Taieri Court for over 20 years. The nurse manager and registered nurse provide on-call cover afterhours and at weekends.</p> <p>There is one roster and staff are allocated residents on a daily basis. On the day of audit there were 33 residents.</p> <p>On morning shift, there are four caregivers (two long and two short shifts). Afternoon shift, there are three care staff (two long and one short shift). Night, there is one caregiver and a cook rostered on night shift. The cook is available to assist as required and care workers who live in close vicinity are available to come in at short notice if required. Shift hours are extended during weekends for morning staff.</p> <p>Staff were visible and were attending to call bells in a timely manner as confirmed by all residents interviewed. Staff interviewed stated that the staffing levels are satisfactory and that the RN and nurse manager provide good support. Residents and family members interviewed reported there are sufficient staff numbers.</p> <p>Activities staff are scheduled five days a week. Separate cleaning staff are rostered.</p> <p>Interviews with staff, residents and family members identified that staffing is adequate to meet the needs of residents.</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>	FA	<p>The residents' 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 electronic record. Residents' files are protected from unauthorised access. Informed consent to display photographs is obtained from residents/family/whānau on admission. Sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public. Entries in records are legible, dated and signed by the relevant care worker or RN. Individual resident files demonstrated service integration. This included medical care interventions and records of the activity's coordinator. Medication charts are stored electronically and protected from unauthorised access.</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>	FA	<p>All residents are assessed prior to entry to the rest home. The service has specific information available for residents/families/whānau at entry and it includes associated information such as the code of rights, advocacy and complaints procedure.</p> <p>There is a comprehensive admission booklet available to all residents/family/whānau on enquiry or admission. The information includes examples of how services can be accessed that are not included in the agreement. Relatives agreed that the service was proactive with providing information.</p> <p>The registered nurse and nurse manager interviewed were able to describe the entry and admission process. The GP is notified of a new admission.</p> <p>Signed admission agreements were sighted and aligns with the ARRC contract.</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>	FA	<p>The service has transfer/discharge/exit policy and procedures in place. The procedures include a transfer/discharge form, and the completed form is placed on file. The service states that a staff member escorts the resident if no family are available to assist with transfer, and copies of documentation, for example, GP letter, medication charts, care plans, are copied and forwarded with the resident.</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</p>	FA	<p>There are medication management policies and procedures in place, which follow recognised standards and guidelines for safe medicine management practice. All medications were stored securely. Medications are checked as part of a monthly medication audit. All eye drops were dated at opening. No expired medications were noted on any trollies or medication storage shelves. Regular recordings of fridge and medication room temperatures were within set limits.</p> <p>A medication round was observed; the registered nurse followed procedure that was correct and safe.</p>

<p>guidelines.</p>		<p>All staff who administer medications have an up-to-date medication competency.</p> <p>The service uses an electronic medication system and charting and administration. All prescribing and administration requirements were adhered to in the 12 medication charts reviewed. The self-medicating policy includes procedures on the safe administration of medicines. Currently one resident self-administers. The resident's self-medicating competency is reviewed on a three-monthly basis. The resident manages safe and secure storage of medications.</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>There is a large, well-equipped kitchen and all meals are cooked on site. Kitchen fridge including the residents' fridge, freezer and meal temperatures are recorded and action is taken as needed. The kitchen was observed to be clean and well organised. The food control plan has been audited and the kitchen is certified for 18 months until February 2022.</p> <p>A registered dietitian is employed by Presbyterian Support Otago (PSO) and there is dietitian input into the provision of special menus and diets where required. A full dietary assessment is completed on all residents at the time they are admitted. The dietitian reviews residents with weight loss every one-to-two months. Residents with special dietary needs have these needs identified in their care plans and these needs are reviewed periodically, as part of the care planning review process. Residents are referred to the dietitian if they have had a 10% change in body weight.</p> <p>A memo is sent to the kitchen alerting the food service manager of any special diets, likes and dislikes, or meal texture required. Resident meetings discuss food as part of their meetings. Residents stated they had some choice in meals offered and both residents and relatives expressed satisfaction with meals provided.</p> <p>Special equipment is available. Internal audits are undertaken, and the food service manager was able to describe the audit processes.</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>	<p>FA</p>	<p>The reason for declining entry to the service is recorded and should this occur, the service stated it would be communicated to the family/whānau and the appropriate referrer. Potential residents would only be declined if there were no beds available or they did not meet the service requirements.</p>

<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>All residents are admitted following a need's assessment and service coordination team prior to admission.</p> <p>The interRAI assessment tool forms the basis of the long-term care plan as well as other risk assessments, dependent on resident needs. The nurse manager and the registered nurse are interRAI trained. Risk assessments are all completed on the electronic resident management system and included: falls, pressure risk, dietary needs, continence and pain. The outcomes of these assessments were reflected in the care plans reviewed.</p> <p>Pain assessments were evidenced as completed with ongoing monitoring recorded, for residents requiring administration of controlled medication as part of a prescribed pain management plan.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>The long-term care plan reflects the interRAI assessment process. All resident files reviewed included a long-term care plan; four with the older version and two with the new version. The new 'My Care Plan' template incorporates the activities, social profile, and activities plan and is very resident focused. Sections are written in the first person to reflect each resident's needs and requirements. The staff interviewed advised that they like the new care plan template as it is easy to read and understand. A daily care plan has also been developed in consultation with residents which provides care staff with a quick reference guide to the resident's care support requirements. All care plans reviewed have been comprehensively completed to reflect the assessed needs. Presbyterian Support Otago has a full range of policies and procedures to support staff to support and care for residents.</p> <p>Short-term care plans (STCPs) are used for short term and acute conditions. All six resident files reviewed identified that family were involved in the care plan development and ongoing care needs of the resident. Residents' files reviewed were integrated and include (but not limited to) input from GP, physiotherapist, dietitian, occupational therapist, diversional therapist, and nursing/caring.</p>
<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>	<p>FA</p>	<p>The care provided is consistent with the needs of residents as demonstrated on the review of the care plans, discussion with family, residents, staff and management.</p> <p>Dressing supplies are available, and a treatment cupboard is stocked for use. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described. Continence management in-service and wound management in-service has been provided as part of annual training. The registered nurse and nurse manager interviewed were able to describe access to specialist services if required.</p>

		<p>Wound assessment and wound management plans are in place for three residents with wounds: two residents with chronic skin conditions and one with a surgical wound from a removal of lesion. There were no residents with pressure injuries.</p> <p>All wounds have documented assessments, treatment plans and wound evaluations documented.</p> <p>Monitoring charts were in use (but not limited to) food/fluid, weights, bowel, behaviours and pain.</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>Taieri Court employs an activities coordinator who is a qualified diversional therapist. This staff member and volunteers provide an activities programme from Monday to Friday and works 30 hours per week.</p> <p>The programme includes residents being involved in the community with social clubs, churches and schools and kindergarten. On admission, a social profile is recorded in conjunction with the resident and family members. This forms the basis of the activities section of the care plan. Reviews are conducted six-monthly as part of the care plan review/evaluation. A record is kept of individual resident's activities and progress notes are completed monthly. The resident/family/EPOA as appropriate is involved in the development of the activity plan. There is a wide range of activities offered. The service has worked on a more resident focused activities programme and has exceeded the standard in this area.</p> <p>The service owns a van. The activities coordinator has a current first aid certificate. There are volunteers that assist with a variety of activities including van outings.</p> <p>Residents and families interviewed confirmed the activity programme was developed around the interest of the residents. Resident meetings are held six weekly and relative/resident meetings six monthly. Feedback on the activities programme is encouraged at meetings and through surveys.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Long term care plans reviewed included documented six-monthly evaluations. InterRAI reassessments and review of risk assessments is also completed at the six-monthly review. A review of medical notes identified GPs have completed reviews at least three-monthly. Short-term care plans were in use for acute changes in health status.</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</p>	FA	<p>The service facilitates access to other services (medical and non-medical) and where access occurs, referral documentation is maintained. Residents' and/or their family/whānau are involved as appropriate when referral to another service occurs. The registered nurse and nurse manager interviewed described the referral process and related form should they require assistance from a wound specialist, continence nurse, speech language therapist, nurse practitioner and dietitian.</p>

<p>disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</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>The infection control manual contains documented policies and procedures for the safe and appropriate storage and disposal of waste and hazardous substances. The health and safety manual includes a policy around safe storage and handling of chemicals. Waste is appropriately managed.</p> <p>Chemicals are secured in designated locked cupboards. Chemicals are labelled, and safety datasheets were available in the laundry and sluice areas. Safe chemical handling training has been provided. Personal protective equipment is available for staff.</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 service building warrant of fitness has been extended for a further 12 months due to Covid-19. This was issued on 24 May 2021 by the Dunedin City Council. A preventative building maintenance programme ensures that all legislation is complied with. A maintenance work notification book is available for staff to communicate with the maintenance person who works eight hours per week and attends to the gardens. The administration person coordinates the required work with the maintenance person regarding any issues or areas that require attention. The facility maintenance schedule is coordinated by the PSO property manager. An annual inspection and walk around of the facility are conducted with the manager to identify any areas that require attention. Hot water temperatures are monitored and recorded monthly. The environment and buildings are well maintained. The maintenance person is available afterhours, if required. Electrical equipment is tested and tagged. All medical equipment has been calibrated and checked. The facility van is registered and has a current warrant of fitness.</p> <p>Corridors within each wing are of sufficient size to allow residents to pass each other safely. There is sufficient space to allow the safe use of mobility equipment. Safety rails are appropriately located.</p> <p>There is an internal courtyard area with seating, tables and shaded areas that are easily accessible. External seating areas, pathways, seating and grounds appear well maintained. All hazards have been identified in the hazard register.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p>	<p>FA</p>	<p>There are four communal showers and eight toilets for residents in the centre of the home. Further resident toilet facilities are available near the lounge and dining area. Resident rooms have hand</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>		<p>washing facilities with soap dispensers and paper towels. Staff and visitor toilets are also provided.</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>	<p>FA</p>	<p>Residents' rooms are of an adequate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Transfer of residents between rooms can occur in the resident's bed and equipment can be transferred between rooms. Mobility aids can be managed in communal toilets and showers. Residents and relatives confirmed satisfaction with their rooms.</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>	<p>FA</p>	<p>The service has a large communal dining room and a large lounge. There are smaller seating areas around the facility for residents and families. Furniture in all areas is arranged in a very homely manner and allows residents to freely mobilise. Activities can occur in the lounges, dining room, activities areas and courtyards and this was confirmed by staff and residents interviewed.</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>All communal laundry is completed off site. Resident's personal washing is completed on site. Residents and relatives expressed satisfaction with cleaning and laundry services. Staff could describe the dirty to clean flow.</p> <p>The service has secure cupboards for the storage of cleaning and laundry chemicals. Chemicals are labelled. Material safety datasheets are displayed in the laundry and are also available in the chemical storage areas.</p> <p>Laundry and cleaning processes are monitored for effectiveness and compliance with the service policies and procedures. Cleaning and laundry staff have completed chemical safety training.</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. The emergency plan manual has been updated to provide easy access to documentation including photographic support. 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. 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 back-up power for emergency lighting is in place. The facility has been wired to provide generator support if required.</p> <p>A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is available at all times. Activities staff are also trained in first aid and CPR procedures.</p> <p>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>Security systems are in place to ensure residents are safe.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</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>FA</p>	<p>General living areas and resident rooms are appropriately heated and ventilated. There are radiator heaters in each room and temperatures can be individually adjusted. Residents have access to natural light in their rooms and there is adequate external light in communal areas. Smoking is only permitted in designated areas.</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>PSO Taieri Court has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. The PSO clinical nurse adviser is the designated infection control nurse for the organisation, with support from the registered nurse and nurse manager at Taieri Court. Infection control is linked to the quality meeting and includes discussion and reporting of infection control matters. The infection control programme has been reviewed annually. Minutes of meetings are available for staff. Education is provided for staff as part of the service education programme.</p> <p>The PSO clinical nurse advisor is part of the Southern DHB aged care locality lead working group which met frequently during Covid lockdown and since. The service has well developed plans for contingency with regards to the various Covid-19 alert levels. There are sufficient supplies of PPE on hand, and training around infection control, hand hygiene, and donning and doffing of PPE has been provided to</p>

		staff. Isolation kits are available for use and the service is currently facilitating vaccination of staff and residents.
<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	There are adequate resources to implement the infection control programme, for the size and complexity of the organisation. The infection control (IC) nurse is the clinical adviser for the organisation. The clinical adviser maintains her practice and has completed training. Taieri Court has external support from the local laboratory infection-control team, Public Health South, the aged residential care infection control nurse employed by the Southern DHB, and the local hospital. Staff interviewed were knowledgeable regarding their responsibilities for standard and additional precautions.
<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	Infection control policy and procedures are appropriate to the size and complexity of the service. Infection control is one of the quality groups within PSO. 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 are reviewed and updated annually.
<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	The infection control policy states that the facility is committed to the ongoing education of staff and residents. The clinical nurse advisor and external providers, who provide the service with current and best practice information, facilitate this. All infection control training is documented, and a record of attendance is maintained. Discussion of infection prevention is documented in resident meeting minutes.
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is</p>	FA	Infection surveillance and monitoring is an integral part of the infection control programme and is described in the infection surveillance policy. Monthly infection data is collected for all infections. The

<p>carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>PSO infection prevention and control (IPC) nurse receives surveillance data that is collated monthly, including strategies for corrective actions. An infection report and short-term care plan is available for recording infections. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly, three monthly and annually. Outcomes and actions are discussed at staff and management meetings.</p> <p>A three-monthly infection report is provided to the PSO clinical governance group. Infection rates are benchmarked with two other Presbyterian Support services in the lower South Island. If there is an emergent issue, it is acted-upon in a timely manner. Reports are easily accessible to the manager and to organisational management. There have been no outbreaks since the previous audit.</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 that the use of restraint is actively minimised. There is a documented definition of restraint and enablers, which are congruent with the definition in NZS 8134.0. The policy includes restraint procedures. Enablers are voluntary. There are no residents with restraint or enablers. Staff are trained in restraint minimisation, challenging behaviour and de-escalation and competencies are completed.</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 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Low	Comprehensive staff appraisals have been completed recently for all staff, however not all staff have had appraisals completed annually as per contractual requirements.	Four of six files reviewed did not evidence appraisals had been completed annually.	<p>Ensure staff appraisals are completed at least annually as per contractual requirements.</p> <p>180 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>Presbyterian Support Otago has developed a new long term care plan template which incorporates the Eden model of care. The organisation identified that the old long-term care plan template which had been in use, was long, very wordy, not user friendly for care staff and was repetitive in terms of standards of care expected. The organisation then worked on a project to improve the long-term care plan which would make it more user-friendly whilst ensuring all aspects of care and support were documented. The new formatted care plan is also written in the first person and reflects the language that the resident would use. The new template is now in use</p>	<p>The PSO organisation has implemented a plan for developing the new care plan format in consultation with facility managers and registered nurses. The new care plan comprises four main sections, plus a 24-hour activity plan and a section around restraint. The first section ‘getting to know me’ is based on information provided by the resident and their family. It is written in the first person and includes their social history and background. The second section ‘interactive me’ includes first person information around social, communication/vision, cognition and mood and behaviour. The third section is ‘supporting me’ and includes all activities of daily living including personal care, mobility/falls, skin and pressure risk, pain, nutrition, continence and sleep and rest. The fourth section is around health monitoring and medication management.</p> <p>The organisation involved senior staff in the development of the new care plan and implemented a plan to introduce the new plan to each facility. Education and training have been provided to senior staff on the new care plan and this has been well received. In conjunction with the new care plan, the organisation identified that many aspects of care are expected of care</p>

		and as reviews come up, all residents care plans will be transferred to the new format.	staff but not well understood. The organisation has also developed a poster which each facility displays. The poster outlines the expectations of care which are prompts and reminders for all staff to follow when providing personal care to a resident. Feedback from staff is that the new care plan is easier to complete and has removed duplications. Care staff also advised that the expectations of care posters assist them to complete all care for residents. The new care plans also assist them in providing personalised and resident centred care.
<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 activities programme is interesting and varied. Feedback about the programme is included in annual surveys and at resident meetings. The 2019 residents survey identified lower rates of satisfaction with the activities programme in terms of; a meaningful range of activities offered, enjoying the range of activities and around having the opportunity to participate in activities outside the home. A corrective action plan was developed and implemented. The 2020 resident survey evidenced higher levels of satisfaction with the activities programme. Residents interviewed also expressed their enjoyment of the programme and appreciated being able to have more input into the programme and being able to be spontaneous.</p>	<p>The 2019 resident satisfaction survey showed that only around 50% of resident responses agreed that they were offered a meaningful range of activities and 20% stated that they did not agree that they were offered a meaningful range of activities. Similar results were provided for the statement on having opportunities to participate in activities outside the home. The service developed corrective actions to address the issues raised. These were implemented in response to the resident survey and feedback around the activities programme and included the activities coordinator attending a PSO led training day focused on resident choice being the centre of planning of activities.</p> <p>During lockdown in 2020, the activities programme was modified with different activities and a new format implemented. At the resident meetings held following lockdown, the residents discussed and agreed to keep the programme changes going as they had enjoyed the spontaneity and the impromptu nature of the programme. New activities were introduced such as attending concerts in the community, outdoor walking groups with the physiotherapist, and new outdoor furniture purchased. Combined activities with other homes in Mosgiel have also been occurring. As a result of the actions implemented, residents were encouraged to put forward ideas and requests for what they would like to do and what might be of interest to them. A greater focus was also placed on spontaneity and resident contribution. The programme still contains regular scheduled activities and other opportunities for requests and choice. The 2020 survey conducted identified an increase in satisfaction with the activities programme. In response to the statement "I am offered a meaningful range of activities", 80% totally agreed and 20% mostly agreed. No residents disagreed with the statement. In response to the statement "I have the opportunity to participate in activities outside the home", 90% totally agreed and 10% mostly agreed. Again, no</p>

			residents disagreed with the statement. The service continues to monitor the satisfaction of the activities programme at resident meetings.
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End of the report.