

Metlifecare Limited - Crestwood

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 The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

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

The specifics of this audit included:

Legal entity:	Metlifecare Limited
Premises audited:	Metlifecare Crestwood
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 15 April 2021 End date: 16 April 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:	37

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

Metlifecare Crestwood provides rest home and hospital level care for up to 41 residents. The service is operated by Metlifecare Limited and managed by a village manager and nurse manager. Residents and families spoke positively about the care provided.

This recertification audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, managers, allied health providers and a general practitioner.

There were no areas identified as requiring improvement. There is one continuous improvement rating in relation to 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.		Standards applicable to this service fully attained.
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Residents and families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumer Rights' (the Code), and these are respected. Services provided support personal privacy, independence, individuality, and dignity. Staff interacted with residents in a respectful manner.

Open communication between staff, residents and families is promoted, and was confirmed to be effective. There are systems in place to ensure family/whanau are provided with appropriate information to assist them to make informed choices on behalf of the residents.

The residents' cultural, spiritual, and individual values and beliefs are assessed and acknowledged. The service has linkages with a range of specialist health care providers in the community.

A complaints register is maintained with complaints resolved promptly and effectively.

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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The Metlifecare Annual Operating Plan is used as the basis for the Metlifecare Crestwood business plan and defines the facility's scope, direction, goals, values and mission statement. Monitoring of the services is provided to the governing body is regular and effective. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and were current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people.

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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The entry to service pathway is clearly outlined in the policies and procedures sighted. Needs Assessment Service Coordination (NASC) team assess residents prior to entry to confirm their level of care. Assessments and care plans are completed and evaluated by the registered nurses (RNs) at the service. Short term care plans are developed for acute problems, these were evaluated and closed out in a timely manner.

Activities plans are completed by two activities coordinator with caregivers covering the weekends, respectively. Planned activities are appropriate to the residents' assessed needs and abilities. In interviews, residents and family/whanau expressed satisfaction with the activities programme in place.

There is a medication management policy in place. The organisation uses an electronic system in e-prescribing, dispensing and administration of medications. Staff involved in medication administration, such as RNs and caregivers, are assessed as competent to do so.

Nutritional needs are provided in line with recognised nutritional guidelines and residents with special dietary needs are catered for.

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 facility meets the needs of residents and was clean and well maintained. There is a current building warrant of fitness. Electrical and biomedical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken onsite and evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised. Residents reported a timely staff response to call bells. Security is maintained.

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.

The organisation has implemented policies and procedures that support the minimisation of restraint. There were no enablers and no restraints in use at the time of audit. The facility has been restraint free for many years. If enablers are required, they are used voluntarily for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

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.
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The infection control management systems are in place to minimise the risk of infection to residents, visitors, and other service providers. The infection control coordinator is responsible for coordinating education and training of staff. Documentation evidenced that relevant infection control education is provided to staff.

Infection data is collated monthly, analysed, and reported during staff meetings. The infection control surveillance and associated activities are appropriate for the size and complexity of the service. Surveillance for infection is carried out as specified in the infection control programme.

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	1	44	0	0	0	0	0
Criteria	1	92	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
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The organisation has documented policies and procedures to meet their obligation in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff and ongoing training was verified in the training records. The Code is displayed around the facility and provided to residents and family/whānau as part of the admission process.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed	FA	The consent policy and procedure references consumer right legislation, including competency/mental capacity. There is also a policy on advanced directives. Staff interviewed understood the principles and practice of informed consent. The service was able to demonstrate that written consent is obtained where required. Clinical files sampled confirmed that informed consent has been gained appropriately using the organisation's standard consent form. These are signed by the enduring power of attorney (EPOA), or residents, and the general practitioner makes a clinically based decision on resuscitation authorisation if required. Staff were observed to gain consent for daily cares. Interviews with residents and relatives confirmed the service actively involves them in decision making.

consent.		
<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>As part of the admission process residents and family/whānau are given a copy of the Code, which includes information on advocacy services. Posters and brochures related to the national advocacy service were displayed and available in the facility. Family members and residents were aware of the advocacy service, how to access this and their right to have support persons. A village resident who is an advocate representative for Crestwood was interviewed and confirmed being involved in supporting residents and family members as and when requested. The SRN and staff provided examples of the involvement of advocacy services in relation to residents' care.</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 are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending to a variety of organised outings, visits, shopping trips, activities, and entertainment. Family/whānau or friends are encouraged to visit or call.</p> <p>The facility has unrestricted visiting hours (unless restrictions are required due to the current Covid-19 pandemic national alert levels) and encourages visits from residents' family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their encounters with staff.</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 and procedure flow chart meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so.</p> <p>There are few complaints made and the complaints register reviewed showed that the two complaints received to date in 2021 and the two complaints received in 2020 have been managed as required. A review process, involving the complainant/family member and staff (where relevant) was thorough and actions taken, where necessary, have been agreed, documented and completed within the timeframes required of the Code. The nurse manager is responsible for complaints management and follow up, with the support of the regional clinical manager as needed. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p> <p>There have been no complaints received from external sources since the previous audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p>	FA	<p>Residents are informed of their rights during entry to service and through the service delivery process. Information about consumer rights legislation, advocacy services and the complaints process are provided on admission and displayed at the reception. All residents received a copy of the code. The Code of Rights</p>

Consumers are informed of their rights.		<p>posters were in English and Maori. The senior registered nurse reported that the Code will be provided in other languages as appropriate, and interpreters will be used as required. Family members and residents interviewed were aware of consumer rights and confirmed that information was provided to them during the admission process.</p> <p>The admission pack outlines the services provided. Resident agreements signed by an enduring power of attorney (EPOA) were sighted in records sampled. Service agreements meet the district health board requirements.</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>There is a policy and procedure regarding resident safety, neglect, and abuse prevention. This includes definitions, signs and symptoms and reporting requirements. Guidelines on spiritual care to residents were documented. The privacy policy references legislation. There were no documented incidents of abuse or neglect in the records sampled. The general practitioner (GP) reiterated that there was no evidence of any abuse or neglect reported. Family/whānau and residents interviewed expressed no concerns regarding abuse, neglect, or culturally unsafe practice.</p> <p>Residents' privacy and dignity are respected. Staff were observed maintaining privacy. Residents are supported to maintain their independence with residents assessed as rest home and hospital level of care. There is a contracted physiotherapist (PT) who visit the facility twice a week for 12 hours. The PT is involved in assessing residents on admission, post fall, including regular monitoring to promote independence and providing manual handling training. Residents were able to move freely into the surrounding areas and in and out of the facility with no restrictions. Records sampled confirmed that each resident's individual cultural, religious, and social needs, values and beliefs had been identified, documented, and incorporated into their care plan.</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>Assessments and care plans document any cultural and spiritual needs. Special consideration of cultural needs is provided in the event of death as described by staff. The required activities and blessings are conducted when and as required. All staff receive cultural awareness training and there were two staff members who identify as Maori. There is a documented assessment process for Māori residents if required. The senior registered nurse (SRN) reported cultural needs would be included in the care plans, if identified. There is access to cultural advice, resources, and documented procedures. There were no residents who identified as Maori on the audit days.</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>	FA	<p>Cultural needs are identified on admission and a care plan is developed to ensure that care and services are delivered in a culturally and/or spiritually sensitive manner in accordance with protocols/guidelines as recognised by the resident and family/whānau. Values and beliefs are discussed and incorporated into the care plan. Family members and residents confirmed they were encouraged to be involved in the development of the long-term care plans. Residents' personal preferences and special needs were included in care plans reviewed.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>The service has documented policies and procedures in place to prevent and minimise incidents of discrimination, coercion, and harassment, sexual, financial, or other exploitation at the service. Family members stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. Residents interviewed reiterated the same. The induction process for staff includes education related to professional boundaries, expected behaviours and the code of conduct. A code of conduct statement is included in the staff employment agreement. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation. The SRN stated that there have been no reported alleged episodes of abuse, neglect, or discrimination towards residents.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service encourages and promotes good practice through ongoing professional development of staff and education for residents. Policies and procedures are linked to evidence-based practice. The general practitioner (GP) confirmed promptness and appropriateness of medical interventions when medical requests are sought.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice. The organisation supports and maintains competencies for staff in manual handling, hand washing, medication administration and interRAI assessments. Staff complete online training and receive external training from the regional clinical managers and local district health board. The organisation supports nursing and care giving student placements from the local training institutes.</p>
<p>Standard 1.1.9: Communication</p>	FA	<p>Family members stated they were kept well informed about any changes to their relative's health status and were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. Communication continued to be maintained even during Covid-19 pandemic lockdown</p>

Service providers communicate effectively with consumers and provide an environment conducive to effective communication.		<p>throughout all national alert levels announced by the Ministry of Health (MOH). This was supported through, but not limited to, emails, phone, and video calls. This was confirmed in residents' records sampled. Staff understood the principles of open disclosure, which is supported by policies and procedures. Personal health and medical information is collected to facilitate the effective care of residents.</p> <p>There were no residents who required the services of an interpreter however staff knew how to access interpreter services if required. Staff can provide interpretation as and when needed and the use of family members and communication cards when required is encouraged.</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>	FA	<p>The Metlifecare planning policy and procedure provides the basis for the annual planning process at facility level, Metlifecare Crestwood included. The Metlifecare clinical director, who is a member of the Metlifecare executive team, and the regional manager interviewed reported that with the new ownership (EQT) and Board, work is underway to develop a new strategic plan. Metlifecare Crestwood has completed a 'Strengths, Weaknesses, Opportunities, Threats' analysis and developed their own annual plan, as required (2020-2021). This was sighted and discussed. The purpose, values, scope, direction and goals of the village and care centre facility are documented and described annual objectives and the associated operational plans. A sample reports to the regional clinical manager were reviewed and showed that adequate information to monitor performance is reported including financial performance, emerging risks and issues and a range of clinical safety and quality indicators. The clinical director also confirmed sufficient information is reported to the executive leadership team and then to the Board.</p> <p>The service is managed by a nurse manager, who reports to the village manager. The nurse manager who holds relevant qualifications and has been in the role since October 2019. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The nurse manager confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through the district health board regional meetings, professional connections within and external to Crestwood and their involvement in auditing activity nationally. Previous attendance at national aged care conferences did not occur in 2020 due to Covid-19 restrictions.</p> <p>The service holds contracts with the Waitemata District Health Board for aged related residential care - hospital and rest home. On the first day of the audit there were 11 hospital residents and 26 rest home residents.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the</p>	FA	<p>When the nurse manager is absent, the village manager takes responsibility for the operational management and a senior registered nurse (RN), with support from the regional clinical manager, oversees clinical responsibilities. Staff reported the current arrangements work well. The nurse manager reported that there is good support provided from the national 'support office' as and when required. This has included for</p>

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.		human resources advice/support, health and safety matters and daily meetings during the level 4 lockdown restrictions.
<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 organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, a regular patient satisfaction survey (with the exception of 2020, due to Covid-19 disruptions), monitoring of outcomes, clinical incidents including infections, pressure injuries and falls and external benchmarking off clinical indicators.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at staff meetings, quality meetings, registered nurse meetings, health and safety committee meetings and management meetings. Clinical information and data/outcomes are also reported to the Metlifecare clinical governance group. A resident representative is on this group.</p> <p>Staff reported their involvement in quality and risk management activities through audit activities, meeting discussions and various improvement projects (e.g., the review of the Covid-19 response and ongoing developments, changes to the breakfast process and increasing physical activity for residents and staff). Relevant corrective actions are developed and implemented to address any shortfalls.</p> <p>Resident satisfaction surveys are normally completed annually, with the exception of 2020, where this was delayed due to Covid-19. The 2021 survey was about to be distributed at the time of audit. The most recent survey in 2019 showed positive results, and where opportunities for improvement were identified, these have resulted in improvement projects (e.g., improvements to activities). Review of the last three residents' meetings minutes also showed a high level of satisfaction and that where issues were raised, these were addressed.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements. Policies are Metlifecare wide policies/procedures in most cases. Policies are based on best practice, and with rare exceptions, were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The nurse manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager was familiar with the Health and Safety at Work Act (2015) and reported support as needed from the national support office. The clinical director discussed management of risks at organisation level and the process for escalation. This was confirmed by the regional clinical manager.</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>Staff document adverse and near miss events on an accident/incident form which is then entered into an electronic management system. A sample of four incidents occurring since January 2021, ranging from a missing resident to a medication error were reviewed. These showed a severity code rating is completed, a full review had occurred with action plans developed, where necessary, and actions followed-up in a timely manner. Where open disclosure was required, this was documented both in the electronic system and in the resident's file.</p> <p>Adverse event data is collated, analysed and reported through to staff and management meetings. The incident reporting system is audited, with the most recent audit showing that sign off/closure of events was an area for improvement. Changes have been made to the process, including increased hours for RNs to complete related work. Discussion at the RN meeting has occurred and a further audit to track progress is to be completed in August.</p> <p>The nurse manager and clinical regional manager described essential notification reporting requirements. A recent Section 31 notification to the Ministry was reviewed. This also involved notification to the police, the DHB and the Metlifecare executive team. There have been no coroner's inquests, issues-based audits or other notifications since the previous audit.</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>	FA	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. The electronic process ensures all elements are consistently completed. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role and was based around their individual needs. Staff records reviewed showed documentation of a thorough process completed, including a self-directed learning package and skill competency checklist. A performance review after a three-month period was sighted followed by a yearly review.</p> <p>Continuing education is planned annually, including mandatory training requirements. The plan was altered in 2020, due to Covid-19 disruptions with groups of 10 staff at a time to accommodate restrictions. The content of the programme was also altered to change the focus as necessary (e.g., an increased focus on Covid-19 requirements and hand hygiene), although a range of other relevant topics were also covered (e.g., abuse & neglect, continence management, moving & handling and food & nutrition). The training programme for 2021 was sighted. Staff reported good support from a Metlifecare educator, the geriatric nurse specialist from the DHB and the hospice service. There has also been an increase in education to</p>

		<p>accommodate the change to hospital level care residents and for specific residents admitted with special needs (e.g., management of nasogastric tubes, dysphagia, negative pressure dressings, acute deterioration, syringe driver management and palliative care). Two RNs have been trained by the hospice service in the 'Palliative outcome initiative' (Poi) to support end of life care.</p> <p>Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. A Metlifecare staff member is the assessor for the Careerforce programme. There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.</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>	FA	<p>There is a Metlifecare documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents, and recent examples of this were discussed with the nurse manager and noted on the rosters reviewed. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported that changes have been made to the roster since the increase in the numbers of residents receiving hospital level care, and since the previous partial provisional audit. This has included an increasing in caregiver hours, the addition of an RN on night plus a senior caregiver team leader role. There were four RNs employed, plus the nurse manager, at the time of audit, with one RN about to finish at the end of the week following the audit. A recruitment process was underway. All RNs are rostered to work 32 hours per week and are available to fill in for unplanned and planned leave. The nurse manager is closely monitoring staffing as the numbers of hospital level residents increase and this is trended, benchmarked and reported to the senior Metlifecare team.</p> <p>Residents and family members interviewed did not report any concerns in relation to staffing. Observations and review of six weeks of rosters confirmed adequate staff cover had been provided, with staff replaced in any unplanned absence, through use of a Metlifecare Crestwood casual pool of staff in relation to caregivers. There has been no external use of bureau staff for at least 18 months.</p> <p>At least one staff member on duty has a current first aid certificate and there is 24 hour/seven days a week (24/7) RN coverage in the hospital.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p>	FA	<p>There is a new electronic record management system in place. Residents' records are held both electronically and paper based. Staff have individual passwords to the residents' records data base, such as the medication management system and on the interRAI assessment tool. The visiting GP and allied health</p>

Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.		<p>providers also have access to the system which supports integration of residents' records.</p> <p>Some residents' records are maintained in hard copy. This includes the admission agreement, consent agreements and the current care plan. All hard copies are kept securely in the locked cupboards. Hard copy archived records are stored safely and securely on site. There is an effective system for retrieving both hard copy and electronically stored residents' records.</p> <p>All records sampled were legible, included the time and date, and the designation of the writer. Progress notes were documented as per organisation's policies and procedures requirements.</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>The entry to service policy includes all the required aspects on the management of enquiries and entry. The admission pack contains all the information about entry to the service. Assessments and entry screening processes are documented and clearly communicated to the family/whānau of choice where appropriate, local communities and referral agencies. Completed Needs Assessment and Service Coordination (NASC) authorisation forms for the rest home and hospital level of care residents were sighted. Residents assessed as requiring rest home and hospital level of care were admitted with consent from EPOAs where appropriate and documents sighted verified this.</p> <p>Records reviewed confirmed that admission requirements are conducted within the required time frames and are signed on entry. Family/whānau interviewed confirmed that they received sufficient information regarding the services provided.</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>Crestwood has a documented process for the management of transfers and discharges. A standard transfer form notification from the DHB is utilised when residents are required to be transferred to the public hospital or another service. Residents and their families are involved in all exit or discharges to and from the service and there was sufficient evidence in the resident's records to confirm this.</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</p>	FA	<p>The medication management policy identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. The service uses an electronic management system for medication prescribing, dispensing, administration, review, and reconciliation. Indications for use are noted for 'as required' medications, allergies are clearly indicated, and photos were current. Administration records are maintained, and drug incident forms are completed in the event of any drug errors. The medication and associated documentation are in place. Medication reconciliation is conducted by the RNs when a resident is transferred back to the service from hospital or any external appointments. The RNs check medicines</p>

practice guidelines.		<p>against the prescription, and these were updated on the pharmacy delivery forms. The GP completes three monthly reviews.</p> <p>There were no expired or unwanted medicines and expired medicines are returned to the pharmacy in a timely manner. Monitoring of medicine fridge temperatures is conducted regularly and deviations from normal were reported and attended to promptly. Monitoring of medication room temperature was maintained. The RNs were observed administering medications safely and correctly. Medications were stored in a safe and secure way in the trollies and locked storeroom. Medication competencies were completed annually for all staff administering medication. The SRN reported that some medication related audits were conducted.</p> <p>There were two residents self-administering medications and they were assessed as competent. Administration records were maintained, and medicines kept in locked containers. Weekly and six-monthly controlled drug stock takes were conducted. Outcomes of pro re nata (PRN) were documented in the electronic management 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>	FA	<p>The food service is run by the kitchen manager and assisted by the cooks and kitchen hands. The kitchen service complies with current food safety legislation and guidelines. There is an approved food control plan for the service which expires 23 July 2021. Meal services are prepared on site and served in the respective dining areas. The menu was recently reviewed by a dietitian on 16 March 2021. The kitchen staff have current food handling certificates. Diets are modified as required and the cook confirmed awareness of dietary needs of the residents. The residents have a nutritional profile developed on admission which identifies dietary requirements, likes, and dislikes. A choice of two menu options is given to residents to choose what they want to have for dinner. These options are completed daily by the activities staff. All alternatives are catered for. The residents' weight was monitored regularly, and supplements provided to residents with identified weight loss issues.</p> <p>The kitchen and pantry were observed to be clean, tidy, and stocked. Labels and dates are on all containers and records of temperature monitoring of food, fridges and freezers are maintained. Thermometer calibrations were completed every three months. Regular cleaning is undertaken, and all services comply with current legislation and guidelines. The residents and family/whānau interviewed indicated satisfaction with the food service. All decanted food had records of use by dates recorded on the containers and no expired items were sighted.</p>
Standard 1.3.2: Declining Referral/Entry To Services	FA	<p>The SRN reported that all potential residents who are declined entry are recorded and when entry is declined relatives are informed of the reason for this and made aware of other options or alternative services available. The person/family is referred to the referral agency to ensure the person will be admitted</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.		to the appropriate service provider.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Residents have their level of care identified through the needs assessment by the NASC agency. Initial assessments were completed within the required time frame on admission, while residents' care plans and interRAI are completed within three weeks, according to policy. Assessments and care plans were detailed and included input from the family/whānau, residents, and other health team members as appropriate. Additional assessments were completed according to the need (e.g., behavioural, nutritional, continence, skin and pressure risk assessments). The RNs utilises standardised risk assessment tools on admission and when required uses the identification, situation, background, assessment and recommendation tool (ISBAR) reporting changes in residents' status. All this is reported to the GP and management team in a timely manner. The PT was involved in the assessment and evaluation process on admission, ongoing monitoring, and post falls, respectively. Wound specialist and mental health team were consulted to assess residents requiring their input. In interviews conducted, family/whānau and residents expressed satisfaction with the assessment process.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	The assessment findings and input from resident and/or family/whānau informs the care plan and assists in identifying the required support to meet residents' goals and desired outcomes. The care plans sampled were resident focused and individualised. Short term care plans were used for short-term needs. Behaviour management plans were implemented as required for some resident either assessed as rest home or hospital level of care with behavioural issues. Family/whānau and residents confirmed they were involved in the care planning process. Residents' files demonstrated service integration and evidence of allied healthcare professionals involved in the care of the residents, such as the mental health services for older people, gerontology nurses, physiotherapist, district nurses, dietitian, and GP.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed	FA	Care plans reviewed evidenced that interventions were adequate to address the identified needs of residents. Significant changes were reported in a timely manner and prescribed orders carried out. The SRN reported that the GP medical input was sought within an appropriate timeframe, that medical orders were followed, and care was person centred. This was confirmed by the GP during interview. Care staff confirmed that care was provided as outlined in the care plan. A range of equipment and resources are available,

needs and desired outcomes.		suited to the levels of care provided and in accordance with the residents' needs. All staff received appropriate training in the management of delirium in the elderly. Food and fluid charts are initiated as required.
<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 planned activities are meaningful to the residents' needs and abilities. The activities are based on assessment and reflect the residents' social, cultural, spiritual, physical, cognitive needs/abilities, past hobbies, interests, and enjoyments. Residents' files sampled reflect their preferred activities and were evaluated regularly or as when necessary. The activities coordinator with the help of the activities assistant develop a monthly activity planner which covers activities for the rest home and hospital residents. These were posted on the notice boards, lounge and in residents' rooms.</p> <p>Residents' activities information was completed in consultation with the family during the admission process. Activities included celebration of residents' birthdays, van outings, board games, regular walks, music, newspaper reading, national and events of the world. Residents' meetings are conducted monthly where various issues are discussed.</p> <p>The residents were observed participating in a variety of activities on the day of the audit. There are planned activities and community connections that are suitable for the residents. Regular outings were completed for all residents except under Covid-19 alert level three and four. Residents and family/whānau interviewed reported overall satisfaction with the level and variety of activities provided.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Residents' long term care plans, interRAI assessments and activity plans were evaluated at least six monthly and updated when there were any changes. Resident care plans were individualised. Relatives, residents, and staff input is sought in all aspects of care. The evaluations record how the resident is progressing towards meeting their goals and responses to interventions. Short term care plans were developed when needed, signed, and closed out when the short-term problem has resolved.</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</p>	FA	<p>Residents and family/whānau are supported to access or seek referral to other health and/or disability service providers. If the need for other non-urgent service is indicated or requested, the GP and the nursing team refers to specialist service providers and the DHB. Referrals are followed up on a regular basis by the GP and the nursing team. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Acute or urgent referrals are attended to and the resident transferred to public hospital if an ambulance if required.</p>

providers is appropriately facilitated, or provided to meet consumer choice/needs.		
<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>	FA	<p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored, and staff interviewed knew what to do should any chemical spill/event occur.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this.</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>A current building warrant of fitness (expiry date 28 October 2021) was publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed, interviews with the maintenance person and observation of the environment. The environment was hazard free, residents were safe, and independence is promoted. New carpet has recently been laid in all common spaces.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting.</p> <p>Any repairs or maintenance required is dealt with as and when requested. Although the facility is an older facility, resident and family members were happy with the environment. This was supported in the 2019 satisfaction survey.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are</p>	FA	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes four showers and six toilets, plus 17 rooms with toilet ensuites. There is also a tilting shower chair available to assist with hair washing and a separate staff toilet. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence.</p>

assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.		
<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>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation. Rooms are personalised with furnishings, photos and other personal items displayed.</p> <p>There is room to store mobility aids, wheelchairs and mobility scooters. Staff and residents reported the adequacy of bedrooms.</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>Communal areas are available for residents to engage in activities. The large lounge space is available for village residents to also gather. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs.</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>Laundry is undertaken on site in a dedicated laundry with good dirty to clean flow. The laundry staff member interviewed demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen, including how to manage any infection outbreak and during the Covid-19 restrictions. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner. This was confirmed in resident meeting minutes reviewed and in the 2019 satisfaction survey.</p> <p>There is a designated cleaning team of two who have received appropriate training, and between them, work six days a week. These staff are guided by cleaning policies and cleaning schedules. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme and the satisfaction surveys, which indicated satisfaction with services.</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>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service on the 12 October 2001. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 29 March 2021. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ's were sighted and meet the requirements for the 41 residents. Water storage tanks are located around the complex. Emergency lighting is regularly tested.</p> <p>Call bells alert staff to residents requiring assistance. Monitoring of the time taken to respond to bells is monitored and reported on with the average time taken being around three minutes, noted on the most recent report. Residents and families reported staff respond promptly to call bells.</p> <p>Appropriate security arrangements are in place as part of the larger village security system, with regular patrols around the village/facility. Doors and windows are locked at a predetermined time.</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>	FA	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows. Heating is provided by electric flat panel heaters in residents' rooms and in the communal areas. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.</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</p>	FA	<p>Crestwood provides an environment that minimises the risk of infection to residents, staff, and visitors by implementing an appropriate infection prevention and control programme. The SRN is the infection control coordinator (ICC) supported by the nurse manager, regional clinical managers and has access to external specialist advice from a GP and DHB infection control specialists when required. A documented role description for the ICC including role and responsibilities is in place.</p> <p>The infection control programme is reviewed annually and is incorporated in the monthly meetings and a review of the education programme is conducted. Staff are made aware of new infections through daily handovers on each shift and progress notes. The infection control programme is appropriate for the size and</p>

size and scope of the service.		<p>complexity of the service.</p> <p>There are processes in place to isolate infectious residents when required. Hand sanitisers and gels are available for residents, staff, and visitors to use. The service developed tools and systems to manage any community outbreaks/lockdowns and if there should ever be any positive cases in the facility. There have been no outbreaks documented and infection control guidelines are adhered to. The service has a comprehensive education programme for staff around flu vaccination and have also provided education on the Covid-19 vaccination programme. Staff interviewed demonstrated an understanding of the infection prevention and control. Restricted visiting times are put in place in response to national COVID-19 pandemic alert levels.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The ICC is responsible for implementing the infection control programme and indicated there are adequate human, physical, and information resources to implement the programme. Infection control reports are discussed at the management, infection control coordinators meetings and monthly staff meetings. The ICC has access to all relevant resident data to undertake surveillance, internal audits, and investigations, respectively. Specialist support can be accessed through the district health board, the medical laboratory, and the attending GP.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The organisation has documented policies and procedures in place that reflect current best practice. Policies and procedures are accessible and available for staff. These were current and have been updated to include COVID-19 requirements. Staff were observed to be following the infection control policies and procedures. Care delivery, cleaning, laundry, and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand washing technique and use of disposable aprons and gloves. Staff demonstrated knowledge on the requirements of standard precautions and have access to policies and procedures.</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>Staff education on infection prevention and control is conducted by the ICC and other specialist consultants. All staff attend an annual infection prevention and control training. A record of attendance is maintained and was sighted. The training education information pack is detailed and meets best practice and guidelines, including COVID-19 requirements. Regional clinical managers are available for support when required from the support office. External contact resources include GP, laboratories, and local district health boards. Staff interviewed confirmed an understanding of how to implement infection prevention and control activities into their everyday practice.</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>The infection surveillance programme is appropriate for the size and complexity of the organisation. Infection data is collected, monitored, and reviewed monthly. Monthly reports are completed and sent to the nurse manager and then regional clinical manager, respectively. The ICC reported that an infection control record is completed when a resident has an infection. Weekly catch-up meetings are completed these are conducted by the regional clinical manager with other ICCs from sister facilities. Benchmarking of infection is completed against other sister facilities. Staff interviewed reported that they are informed of infection rates at handovers, monthly staff meetings and through compiled reports. The GP is informed within the required time frame when a resident has an infection and appropriate antibiotics are prescribed to combat the infection, respectively.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. Metlifecare Crestwood is a restraint free facility. On the day of audit there were no residents using restraints and no residents using enablers. This was confirmed in the restraint register and from staff interviews. Should enablers be required, these are the least restrictive and used voluntarily at the request of the resident.</p> <p>The restraint coordinator interviewed provides support and oversight for enabler and restraint management, should this ever be required. They demonstrated a sound understanding of the organisation's policies, procedures and their responsibilities. Restraint would only be used as a last resort when all alternatives had been explored. Current alternatives to restraint were discussed, including involvement of the physiotherapist in assessing the most appropriate bed heights for residents at risk of falling. All necessary documentation is available should restraint be required.</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
Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.	CI	There is a full range of social activities that are available on the weekly programme for all residents to participate in. Residents who are assessed as rest home and hospital level of care are invited to specific activities that are appropriate for their level of ability and these are used to facilitate emotional and physical wellbeing. Active involvement and promotion of residents' directed care approach is one of Crestwood's annual goals which is in line with Metlifecare strategic goals. This project has resulted in each staff member developing an annual goal to support the service's strategic goals which have been documented and evaluated through 'Connect 2' process. Furthermore, the service conducted a workshop on resident directed care approach in line with the strategic goals. This was to ensure staff were empowered and knowledgeable in activities promotion. Each staff member also developed an	The achievement of the quality improvement project in the activities programmes and implementation of the programme is rated beyond the expected full attainment. This has improved participation significantly, stimulated interest, created a homely environment for residents minimising deinstitutionalisation, enabled residents to build more meaningful relationships within the service and outside community at large, and reducing a sense of loneliness, boredom, and ageism. Positive outcomes have been measured in staff, resident, and relative satisfaction with ongoing positive feedback from residents and family members. This was confirmed through residents' meeting minutes reviewed, and interviews with residents, families, and staff members, respectively. In 2019, the resident and family satisfaction survey showed that 87% expressed great satisfaction and contentment with activities conducted at the service. The outcomes were positive and have made residents become more interested in attending the daily activities. Documented evidence of daily activities participation records

		<p>annual goal to be part of the activities.</p> <p>The activities in the programme are varied and unique when compared to previous years resulting in record high attendances. This has stimulated interest and promoted physical activity, thereby reducing falls and boredom in the process. Additional activities were introduced, and this included music therapy conducted by a music therapist who visit for 45 minutes weekly, intergenerational involvement included kindergarten children visits to perform various activities, pet therapy and allowing residents to move into the facility with their cats. There was an increase in one-on-one activities during Covid-19 alert lockdowns. Use of video calling, 'WhatsApp', 'Skype' and text messaging to family members was implemented. There is an annual walkathon and village residents and staff play ukulele. Daily menu options are included as part of the activities programme and all residents interviewed reported that they look forward to this.</p> <p>Extensive renovations to the activities lounge with new blinds, cupboards, furniture, indoor plants, craft area, installation of heat pumps to warm up the building and a change of carpet has stimulated residents to join in activities and made the environment more suitable and relaxing for residents.</p>	also confirmed this.
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End of the report.