Park Lane Retirement Village Limited - Park Lane lifecare

Introduction

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

The audit has been conducted by 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:	Park Lane Retirement Village Limited
Premises audited:	Park Lane Lifecare
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 29 October 2020 End date: 30 October 2020
Proposed changes to current services (if any):	
Total beds occupied across all premises included in the audit on the first day of the audit: 47	

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

Park Lane Lifecare is owned and operated by the Arvida Group. The service provides care for up to 87 residents with 42 dual-purpose beds in the care centre and up to 45 serviced apartments certified to provide rest home level care. On the day of the audit, there were 47 residents in total.

This certification audit was conducted against the relevant Health and Disability Services 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, staff, management, and general practitioner.

There is a village manager (non-clinical) who has been in the role for three months and has previous experience in healthcare management roles. The village manager is supported by a clinical manager (registered nurse) in the care centre, and the national quality manager.

Residents and the general practitioner interviewed all spoke positively about the care and support provided.

The service implements the organisations quality and risk management programme. An induction and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place.

This audit identified no areas for improvement. The service has been awarded continuous improvements around good practice, quality and risk management, the wellness programme and food service.

Consumer rights

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

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

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.

Park Lane lifecare has a current business plan and a quality and risk management programme that outlines goals for the year. Meetings are held to discuss quality and risk management processes. An internal audit programme identifies corrective actions and areas for improvement which have been implemented. Residents'/family meetings are held regularly, and residents and families are surveyed annually. Health and safety policies, systems and processes are implemented to manage risk. Incidents are collated monthly and reported at facility meetings. Falls prevention strategies are in place that includes the analysis of falls incidents. There is an annual education and training programme in place. Appropriate employment processes are adhered to and

all employees have an annual staff appraisal completed. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		All standards applicable to this service fully attained with some standards exceeded.

There is an admission package available prior to or on entry to the service. The registered nurses are responsible for each stage of service provision. A registered nurse assesses, plans and reviews residents' needs, outcomes and goals with the resident and/or family/whānau input. InterRAI assessments are utilised and link to care plans. Resident files included medical notes by the general practitioner and visiting allied health professionals. Medication policies reflect legislative requirements and guidelines. Registered nurses, enrolled nurses and senior wellness partners (caregivers) responsible for administration of medicines complete education and medication competencies. The medicine charts were reviewed at least three-monthly by the general practitioner.

An integrated activity programme is implemented for residents. Residents report satisfaction with the activities programme. Residents' food preferences and dietary requirements are identified at admission and all meals are cooked on site. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

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.

Park Lane Lifecare has a current building warrant of fitness. There are documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. Chemicals are stored safely throughout the facility. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade. Resident bedrooms are personalised with ensuites. Documented systems are in place for essential, emergency and security services. Documented policies and procedures for the cleaning and laundry services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services. Documented systems are in place for essential, emergency and security services. All registered nurses hold a current first aid certificate.

Restraint minimisation and safe practice

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

The service has policies and procedures to ensure that restraint is a last resort. On the day of the audit there were no residents with any restraints and two residents using an enabler. Staff receive training in restraint minimisation.

Infection prevention and control

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

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

Covid-19 was managed and well documented. Policies, procedures and the pandemic plan have been updated to include Covid-19. There were adequate supplies of outbreak management equipment sighted.

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	3	42	0	0	0	0	0
Criteria	4	89	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 Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) policy and procedure is implemented. Discussions with seven clinical staff (four wellness partners [caregivers], two registered nurses [RN], one enrolled nurse [EN], and one wellness leader) confirmed their familiarity with the Code. Interviews with eight residents (five rest home and three hospital) confirmed the services being provided are in line with the Code. The Code is discussed at resident, staff and quality risk/health & safety meetings.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	Informed consent processes are discussed with residents (as appropriate) and relatives on admission. Written general and specific consents were evident in the long-term resident files reviewed. Wellness partners (caregivers) and RNs interviewed confirmed consent is obtained when delivering cares. Advance directives identified the resident resuscitation status. Advance directives and medically initiated 'do not resuscitate' had been appropriately signed by the resident and general practitioner (GP). Copies of EPOA are contained within the resident file where appropriate. A sample of seven resident files were reviewed. Signed admission agreements were sighted in the long-term resident files reviewed. General consents were also included as part of the admission agreement.

Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	A policy describes access to advocacy services. Staff receive training on advocacy. Information about accessing advocacy services information is available in the entrance foyer. This includes advocacy contact details. The information pack provided to residents at the time of entry to the service provides residents and family/whānau with advocacy information. Advocate support is available if requested. Interviews with staff and residents informed they are aware of advocacy and how to access an advocate.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents are encouraged to be involved in community activities and maintain family and friends' networks. On interview, staff stated that residents are encouraged to build and maintain relationships. All residents interviewed confirmed that relative/family visiting could occur at any time.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The service has a complaints policy and procedure in place and residents and their family/whānau are provided with information on the complaints process on admission via the information pack. Complaint forms are available at each entrance of the services. Staff are aware of the complaints process and to whom they should direct complaints. A complaints register is available. There have been three complaints received in 2020 year to date and four made in 2019. The complaints reviewed have been managed appropriately with acknowledgement, investigation and response recorded. Corrective actions requests were implemented for two of the recent complaints made in 2020. Residents interviewed advised that they are aware of the complaints procedure and how to access forms. The village manager has regular meetings with the residents to discuss any concerns that they may have.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	There are posters of the Code on display throughout the facility and leaflets are available in the foyer of the facility. The service can provide information in different languages and/or in large print if requested. Information is also given to next of kin or enduring power of attorney (EPOA) to read with the resident and discuss. On entry to the service, the village manager or clinical manager discusses the information pack with the resident and the family/whanau. The information pack includes a copy of the Code.
Standard 1.1.3: Independence, Personal	FA	The service has policies that align with the requirements of the Privacy Act and Health Information Privacy Code. Staff were observed respecting resident's privacy and could describe how they manage maintaining

Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.		privacy and respect of personal property. There is a policy that describes spiritual care. Church services are conducted regularly. All residents interviewed indicated that resident's spiritual needs are being met when required. Staff receive training on abuse and neglect. Staff interviewed could describe how they ensure privacy is maintained.
Standard 1.1.4: Recognition Of Māori Values And Beliefs 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.	FA	The service has established cultural policies to help meet the cultural needs of its residents. There were no residents that identified as Māori at the time of the audit. The service has established links with local Māori community members who provide advice and guidance on cultural matters. Cultural and spiritual practice is supported and identified needs are incorporated into the care planning process and review as demonstrated in the resident files sampled. Discussions with staff confirmed that they are aware of the need to respond to cultural differences.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	The service has established cultural policies aimed at helping meet the cultural needs of its residents. Residents interviewed reported that they were satisfied that their cultural and individual values were being met. Information gathered during assessment including resident's cultural beliefs and values, is used to develop a care plan, which the resident (if appropriate) and/or their family/whānau are asked to consult on. Staff receive training on cultural safety/awareness.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	The facility has a staff code of conduct, which states there will be zero tolerance against any discrimination occurring. The abuse and neglect processes cover harassment and exploitation. Residents interviewed reported that the staff respected them. Job descriptions include responsibilities of the position, ethics, advocacy, and legal issues. The orientation and employee agreement provided to staff on induction includes standards of conduct.
Standard 1.1.8: Good Practice Consumers receive services of	CI	The service has policies to guide practice that align with the health and disability services standards, for residents with aged care needs. Staffing policies include pre-employment and the requirement to attend

an appropriate standard.		orientation and ongoing in-service training. Residents spoke positively about the care and support provided. Staff interviewed had a sound understanding of principles of aged care and stated that they feel supported by the management team. Park Lane Lifecare has fully embedded the Arvida Attitude of Living Well through the wellness/household model. The service has been proactive in implementing the Attitude of Living Well framework within the five pillars (eating well, moving well, resting well, thinking well, and engaging well). Small groups of residents are supported within the care communities by decentralised self-led teams of employees that together create a home, nurture relationships, determine their own lives and build community. Residents are encouraged and supported to create a comfortable living space suited to their particular needs and personal tastes.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Residents interviewed stated they were welcomed on entry and given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Twelve incident/accidents reviewed had documented evidence of family notification or noted if family did not wish to be informed. Interpreter services are available as required.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Park Lane lifecare is owned and operated by the Arvida Group. The service provides care for up to 87 residents in total (42 beds in dual-purpose rooms in the care centre and 45 serviced apartments certified for rest home level care). On the day of the audit there were 47 residents in total, including 21 rest home residents and 20 hospital residents in the care centre and six rest home residents in the serviced apartments including one resident on respite care. All residents were under the age-related residential care (ARRC) agreement. The village manager has been in the role for three months. She previously worked for district health board (DHB) for 10 years in management roles. A clinical manager has been in the role for one year having previously been an RN at the facility for 3 years. The village manager provides a monthly report to the Arvida CEO on a variety of operational issues. Arvida has an overall business/strategic plan. The organisation has a philosophy of care, which includes a mission statement. Park Lane lifecare has a business plan 2020/2021 and a quality and risk management programme. The clinical manager has completed in excess of eight hours of professional development in the past twelve months.

Standard 1.2.2: Service Management 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.	FA	In the absence of the village manager, the clinical manager is in charge. Support is provided by the head of wellness operations, the general manager wellness and care and the wellness and care staff.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	There is an implemented quality and risk management system in place at Park Lane which is designed to monitor contractual and standards compliance. There is a 2020/2021 business/strategic plan that includes quality goals and risk management plans for Park Lane. There is an established culture of seeking to continually review and analyse data to improve resident outcomes. The village manager and clinical manager are responsible for providing oversight of the quality and risk management system on site, which is also monitored at organisational level. Interviews with staff confirmed that there is discussion about quality data at various facility meetings. Arvida Group policies are reviewed at least every two years across the group. Data is collected in relation to a variety of quality activities and an internal audit schedule has been completed. Areas of non-compliance identified through quality activities are actioned for improvement. All staff interviewed could describe the quality programme corrective action process. Restraint and enabler use (when used) is reported within the bi-monthly quality improvement and three-monthly clinical/RN meetings. Residents/relatives are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families. The January 2020 resident/relative satisfaction survey overall result shows 100% satisfaction with services provided. There were no improvement areas required from the survey. Resident/family meetings occur two-monthly and the results of the satisfaction survey have been discussed at the meeting. The service has a health and safety management system that is regularly reviewed. Risk management, hazard control and emergency policies and procedures are being implemented and are monitored by the health and safety committee at the monthly meeting. There are also monthly national health and safety meetings conducted online through Zoom. The village manager and clinical manager are part of the health and safety committee. Hazard identification forms and an up-to-date hazard register is in place through the Mango system. The service had weekly meetings during Covid-19 throughout the alert levels. Falls prevention strategies are implemented including identifying residents at higher risk of falling and the

		identification of interventions on a case-by-case basis to minimise future falls.
Standard 1.2.4: Adverse Event Reporting 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.	FA	There is an accidents and incidents reporting policy. The clinical manager investigates accidents and near misses and analysis of incident trends occurs. There is a discussion of incidents/accidents at staff meetings including actions to minimise recurrence (link CI 1.2.3.6). An RN conducts clinical follow-up of residents. Incident forms reviewed for August and September 2020 demonstrated that appropriate clinical follow up and investigation occurred following incidents. Neurological observation forms were documented and completed for six reviewed unwitnessed falls or potential head injuries. Discussions with the village manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There has been one section 31 incident notification made since the last audit for a stage four pressure injury in September 2019, and the public health service was notified of an outbreak in 2019.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	There are human resource management policies in place. The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. Nine staff files were reviewed (one clinical manager, two RNs, four wellness partners, one wellness leader and one kitchen manager). There is evidence that reference checks were completed before employment was offered. Annual staff appraisals were evident in all five staff files reviewed. A copy of practising certificates is kept. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Completed orientation is on files and staff described the orientation programme. The in-service education programme for 2019 has been completed and the plan for 2020 is being implemented. Discussions with the wellness partners and RNs confirmed that Altura online training is available and implemented by staff. More than eight hours of staff development or in-service education has been provided annually. There are eight RNs at Park Lane and six have completed interRAI training. The village manager, clinical manager and RNs are able to attend external training, including sessions provided by the DHB. There are 29 wellness partners in total with 83% having achieved either National Certificate level 4 (17) and level 3 (7). Competencies completed by staff included medication, insulin, wound care, manual handling, hand hygiene, syringe driver and restraint, there was an up-to-date register.
Standard 1.2.8: Service Provider Availability Consumers receive timely,	FA	Park Lane has a weekly roster in place which provides sufficient staffing cover for the provision of care and service to residents. The service has a total of 71 staff (including 10 casual) in various roles. Staffing rosters were sighted and there is staff on duty to meet the resident needs. The village manager and

appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.		clinical manager work 40 hours per week and are available on call after-hours for any operational and clinical concerns respectively. There is at least one RN on duty at all times. The RN on each shift is aware that extra staff can be called on for increased resident requirements. There are dedicated housekeeping and laundry staff. Interviews with staff and residents confirmed there are sufficient staff to meet the needs of residents. The service has 21 rest home residents and 20 hospital residents in the care centre. There is a RN rostered on the morning, afternoon and night shifts. The RNs are supported by 10 caregivers (two from 8 am to 4.30 pm, three from 7 am to 3.30 pm and five from 8 am to either 1.30 pm or 2.30 pm) on the morning shift, five caregivers (two from 3 pm to 11.30 pm and three from 4 pm to 9.30 pm) on the afternoon shift and two caregivers on at night (11.30 pm to 7.30 am). In the serviced apartments there are six rest home residents (including one on respite care). There is an RN or EN rostered on the morning shift who is supported by three caregivers (two from 8.30 am to 3 pm and one from 7 am to 1.30 pm) rostered in the morning and two caregivers (one from 3 pm to 11.30 pm and one from 4 pm to 9.30 pm) in the afternoon. One of the care centre night caregivers covers the serviced apartment residents. The care centre RN covers the afternoon and night shifts in the serviced apartments.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Residents' electronic files are protected from unauthorised access by individual passwords. Other residents or members of the public cannot view sensitive resident information. Entries in records are legible and dated by the relevant caregiver or RN.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	Residents' entry into the service is facilitated in a competent, equitable, timely and respectful manner. Admission information packs on the services and levels of care are provided for families and residents prior to admission or on entry to the service. All admission agreements reviewed align with all contractual requirements and kept within the electronic file. Exclusions from the service are included in the admission agreement.

Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Planned exits, discharges or transfers are coordinated in collaboration with the resident and relatives to ensure continuity of care. There were documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. The 'yellow envelope' system is used for transfers to hospital and often involve a verbal handover. The residents and their relatives were involved for all exit or discharges to and from the service.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	There are policies and procedures in place for safe medicine management. Medications are stored safely in the locked boxes in the resident rooms. Clinical staff who administer medications (RNs, enrolled nurses and caregivers) have been assessed for competency on an annual basis and attend annual medication education. Registered nurses have completed syringe driver training. All medication (blister packs) are checked on delivery against the electronic medication charts by one RN and one caregiver (night staff). Weekly checks of extra medications (non-blister packed medications including inhalers and creams) held in the treatment room has been performed weekly to ensure there is no expired medication in stock. There was one self-medicating rest home level resident. A competency was sighted and has been reviewed by the GP three monthly. The medication fridge is checked daily and temperatures are maintained within the acceptable temperature range. Medication room temperatures are recorded and have remained within acceptable ranges. A fan has been installed into the treatment room to ensure the temperature does not exceed the recommended 25 degrees Celsius. Fourteen electronic medication charts were reviewed and met prescribing requirements. Medication charts had photo identification and allergy status notified. The GP had reviewed the medication charts at least three-monthly. 'As required' medications had prescribed indications for use.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	CI	The food services are overseen by a food services manager. All meals and baking are prepared and cooked on site by two qualified chefs and one cook who are supported by kitchen assistants, and afternoon kitchenhands. All food services staff have completed food safety training. The Arvida seasonal menu is reviewed twice yearly and includes resident references. The cook receives resident dietary profiles and is notified of any dietary changes for residents. Dislikes and special dietary requirements are accommodated including food allergies and gluten free diets. The menu provides pureed/soft meals using pure foods. The cook described meeting with residents for the food forums. The kitchen is adjacent to the serviced apartments dining room. Meals are delivered to the satellite kitchens on the first floor (care centre) and serviced apartments on the second floor in hotboxes. Food is transferred to the preheated bain maries in the satellite kitchens and served to residents by caregivers. The food control plan has been verified and expires 14 June 2021. Freezer, fridge and end cooked, reheating (as required), cooling and serving temperatures are taken and recorded daily. The dishwasher

		rinse and wash temperatures are taken and recorded. All perishable foods and dry goods were date labelled. A cleaning schedule is maintained. Staff were observed to be wearing appropriate personal protective clothing. Chemicals were stored safely. Residents in the care centre who have breakfast in the dining room have a choice of a continental breakfast served by the breakfast cook. Trays are set up and provided to residents who prefer breakfast in their rooms. Buffet breakfasts are in place in line with the household model in the serviced apartments. Arvida Park Lane have exceeded the standard around food services.
Standard 1.3.2: Declining Referral/Entry To Services 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.	FA	There is an admission information policy. The reasons for declining entry would be if the service is unable to provide the level of care required or there are no beds available. Management communicates directly with the referring agencies and family/whānau as appropriate if entry was declined.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	The RN completes an admission interim assessment including relevant risk assessment tools. Risk assessments are completed six-monthly or earlier due to health changes. InterRAI assessments and long-term care plans were completed within the required timeframes. The outcomes of assessments were reflected in the needs and supports documented in the care plans on the electronic system. Other available information such as discharge summaries, medical and allied health notes and consultation with resident/relative or significant others were included in the long-term care plans of the files reviewed.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Resident care plans on the resident electronic system for all resident files reviewed were resident focused and individualised. Support needs as assessed were included in the long-term care plans. The electronic care plan identifies interventions that cover a comprehensive set of goals including managing medical needs/risks. Care plans include the involvement of allied health and community workers to assist the residents in meeting their specific goals around wellbeing. Key symbols on the resident's electronic home page identity current and acute needs such as (but not limited to); current infection, wound or recent fall. There was evidence of allied health care professionals involved in the care of the resident including physiotherapist, podiatrist, speech and language therapist, community mental health services and wound

		care specialist.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	When a resident's condition alters, the registered nurse initiates a review and if required a GP visit or nurse specialist consultant. Care plans reflect the required health monitoring interventions for individual residents. Wellness partners (caregivers) and RNs sign a care activity worklog with scheduled tasks and monitoring charts including repositioning, bowel chart, behaviour chart, food and fluid chart, weight, blood pressure monitoring, blood sugar levels, neurological observations and toileting regime. Monitoring charts are well utilised. Relatives are notified of all changes to health as evidenced in the electronic progress notes. Caregivers interviewed stated there are adequate clinical supplies and equipment provided including continence, wound care supplies and pressure injury prevention resources. There is access to a continence and stoma specialist as required. Residents interviewed reported their needs were being met. There was documented evidence of relatives' involvement in resident care on admission and the case conference (six-month review) notes. Wound assessments. wound management plans with body maps, photos and wound measurements were reviewed on the electronic system for 18 current wounds: (12 hospital level wounds including one resident with three wounds, and six rest home level). Wounds included four very superficial abrasions, one injury when cutting nails, three surgical wounds, two lesions, six skin tears and two supra-pubic catheter sites. The skin tears were all categorised, and the nurses could describe when they would refer residents with wounds to the nurse specialists. There was one stage 2 pressure injury identified which had an incident report completed. Pressure relieving equipment was in use. Progression of chronic wounds were evidenced as discussed with the GP.
Standard 1.3.7: Planned Activities 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.	CI	The service wellness leader works 30 hours a week between Monday and Friday and has been in the role for a year. The programme in the care centre runs across Monday to Friday with the wellness partners (caregivers) providing activities over the weekend. A resident leisure profile is completed soon after admission. Individual leisure plans were seen in resident electronic files. The activity coordinators are involved in the six-monthly review with the RN. There are occasional facility-wide activities held to include the residents from the serviced apartments and the care centre. The wellness (activity) team provide individual and group activities. These include (but not limited to); daily exercise groups, newspaper reading, board games, quizzes, happy hours, outdoor garden walks and activities, hand and nail care and group games. Community visitors include volunteers, church services, school children and entertainers. The service has a van for outings into the community. The men gather and catch up over a beer to reminisce and have a general catch up. Ladies have a cheese and wine

		afternoon, and manicure/pamper days. The café is well utilised by residents and relatives both from the serviced apartments and the care centre. Residents receive a copy of the fortnightly programme which has set daily activities and additional activities, entertainers, outings, church services and movies. The programme aligns with the Wellness model of thinking well, engaging well and moving well. Activities are held in the main lounge dining room, and smaller group activities can run concurrently in the smaller lounge/library. The local school children visit the residents, and there is an intervillage indoor bowl competition. Household meetings are held two weekly and a care centre meeting is held once a month. Residents interviewed described providing suggestions for the next planner. One on one activities such as individual walks, chats and hand massage occur for residents who are unable to participate in activities or choose not to be involved in group activities. The service has exceeded the standards around provision of activities in the care centre.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	All initial care plans for long-term residents were evaluated by the RN within three weeks of admission. Long-term care plans have been evaluated by the RN six monthly or earlier for any health changes in the electronic resident files reviewed. Relatives are invited to attend the multidisciplinary review meeting (case conference) notes are kept on the electronic system. Written evaluations reviewed, identified progression towards meeting goals. The GP reviews the residents at least three monthly or earlier if required. Ongoing nursing evaluations occur as indicated and are documented within the electronic progress notes.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	There are documented policies and procedures in relation to exit, transfer or transition of residents. Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. Discussion with the registered nurses identified that the service has access to a wide range of support either through the GP, specialists and allied health services as required.
Standard 1.4.1: Management Of Waste And Hazardous	FA	There are policies regarding chemical safety and waste disposal. All chemicals were clearly labelled with manufacturer’s labels and stored in locked areas. Cleaning chemicals are dispensed through a pre-mixing

Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.		(closed system) unit. Safety data sheets and product sheets are available. Sharps containers are available and meet the hazardous substances regulations for containers. Gloves, aprons and visors are available for staff and they were observed to be wearing these as they carried out their duties on the day of audit. There are sluice rooms with appropriate personal protective clothing. Staff have completed chemical safety training by the chemical provider.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The service employs a full-time maintenance manager who is on call after hours. The maintenance manager ensures daily maintenance requests are addressed and a planned maintenance schedule is maintained. Essential contractors are available 24 hours. Electrical testing is completed annually by an external contractor. The building has a current building warrant of fitness that expires 2 March 2021. Annual calibration and functional checks of medical equipment including hoists, is completed by an external contractor. The maintenance team completes regular visual and physical checks of transferring equipment, beds and call bells. Hot water temperatures in resident areas are monitored monthly and are maintained within acceptable ranges. The care centre is situated on the first floor. Serviced apartments are situated on the ground and second floors. There are stair and lift access between the floors. The facility has wide corridors and sufficient space for residents to safely mobilise using mobility aids or for the use of hospital recliners on wheels. There is safe access to the well-manicured outdoor areas and courtyards. Seating and shade are provided. The caregivers and RNs interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities 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.	FA	All dual-purpose resident rooms on the first floor have ensuites. The studio apartments on the ground and second floor also have ensuites. Ensuite hand basin, toilet and shower facilities are of an appropriate design to meet the needs of the residents. There are communal toilets with privacy locks located near the communal areas. Residents interviewed confirmed care staff respect the resident's privacy when attending to their personal cares.

Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	All rooms are spacious. There is adequate room to safely manoeuvre mobility aids or hoists. Residents and families are encouraged to personalise bedrooms. A tour of the facility evidenced personalised rooms which included the residents own furnishing and adornments.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	The dual-purpose care floor has a large open plan dining and lounge area where most group activities take place. A second smaller lounge includes a library and internet access for residents and is available for quieter activities and visitors. There are seating alcoves appropriately placed within the facility. All communal areas are accessible to residents. Caregivers assist to transfer residents to communal areas for dining and activities as required.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	There are policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. There are dedicated laundry and housekeeping staff on duty seven days a week. The laundry assistant and housekeeper interviewed stated they have completed chemical safety training and training around laundry processes and housekeeping. The laundry is located on the ground floor and laundry is transported in covered trolleys by lift to the laundry. The laundry has an entry and exit door. There is appropriate personal protective-wear readily available. The cleaner's trolley is lockable and is stored in a locked area when not in use. The housekeeper described the extra cleaning required in line with current infection control Covid-19 guidelines. Internal audits and the chemical provider monitor the effectiveness of the cleaning and laundry processes.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	There is an emergency and evacuation procedures and responsibilities plan in place. A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. Six-monthly fire evacuation practice documentation was sighted, with the last fire evacuation drill occurring on 7 October 2020. A contracted service provides checking of all facility equipment including fire equipment. Fire training and security situations are part of orientation of new staff and include competency assessments. Emergency equipment is available at the facility (including a generator and defibrillator). There are adequate supplies in the event of a civil defence emergency including civil defence and first aid kits, food, water (bottled and header ceiling tanks), blankets and gas cooking (gas hobs and 3 x BBQs). There are also sufficient supplies of outbreak/pandemic and personal protection equipment (PPE)

		available. Short-term backup power for emergency lighting is in place. A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is available at all times. All RNs hold a current first aid certificate. There are call bells in the residents' rooms, and lounge/dining room areas. Residents were observed to have their call bells in close proximity.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	Residents are provided with adequate natural light and safe ventilation. The environment is maintained at a safe and comfortable temperature. Resident room temperatures are monitored through a central computer system. The residents interviewed confirmed temperatures were comfortable.
Standard 3.1: Infection control management 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.	FA	The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the quality management system. The clinical manager is the designated infection control coordinator with support from an enrolled nurse and other members of the infection control team, who are representative of the facility. Minutes are available for staff to read. Internal audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The Arvida infection control programme has been reviewed annually. Hand sanitiser is available at the main entrance and throughout the facility. Adequate supplies of personal protective equipment were sighted.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The designated infection control (IC) coordinator has been in the role for two years. The enrolled nurse interviewed (infection control committee member) has been in the committee for six years. Members of staff complete on-line Altura learning for infection control education. In-service education is held on topical issues by the infection control coordinator. The infection control coordinator has access to expertise within the organisation, local laboratory, DHB infection control team, public health team, and the GPs. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. There is a Covid-19 resource folder and pandemic/outbreak cupboard with sufficient personal protective clothing and hand sanitisers. Isolation kits and foot pedal bins are set up ready for use in isolation rooms. There were weekly zoom meetings with Arvida support office and a consultant virologist during lockdown

		providing a forum for discussion and support for facilities. Screening logs were maintained during the lockdown levels. An electronic wellness declaration is completed by all visitors and contractors on entering the facility.
Standard 3.3: Policies and procedures 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.	FA	Arvida group infection control policies and procedures meet best practice. 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. Policies and procedures are reviewed at support office in consultation with infection control coordinators. Policies are available on the intranet. Policies and the pandemic plans have been updated to include Covid-19.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The infection control policy states that the facility is committed to the ongoing education of staff and residents. All staff complete infection control education on the Altura system. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in their medical records. Extra education was provided during the Covid-19 period. Compulsory education sessions were made available for staff in February and April around donning and doffing personal protective equipment (PPE), handwashing, and an online course. Zoom meetings were held with the Arvida infection control team and the consultant virologist.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been	FA	Infection surveillance is an integral part of the infection control programme and is described in the Arvida group infection control manual. Monthly infection data is collected for all infections based on signs, symptoms and definition of infection. Infections are entered into the infection register on the electronic data base. Surveillance of all infections (including organisms) is entered onto a monthly infection summary. This data is monitored and analysed for trends monthly and annually. Infection control surveillance is discussed at facility meetings and meeting minutes are displayed for staff. Action plans are

specified in the infection control programme.		required for any infection rates of concern. Internal infection control audits are completed with corrective actions for areas of improvement. The service receives benchmarking feedback from support office. There was one confirmed respiratory outbreak in 2019, and a small cluster of influenza A. The outbreak and suspected outbreak were logged, documented, and reported to the public health team.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The service has documented systems in place to ensure the use of restraint is actively minimised. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. On the day of the audit there were no residents with any restraints and two residents using enablers (both bedrails). The files for the residents with enablers showed that enabler use was voluntary. Assessment, consent form and the use or risks associated with the enabler were evidenced in the resident file reviewed. Staff receive training on restraint minimisation and enabler use.

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 1.1.8.1 The service provides an environment that encourages good practice, which should include evidence-based practice.	CI	The wellness/household model focuses on the relationship between the care team and the resident as partners in the pursuit of a rich and meaningful life. The emphasis is on supporting each resident to live well and be actively engaged in their life the way they want it to be. Residents are supported within the care communities by decentralised self-led teams of employees that together create home, nurture relationships, determine their own lives and build community. Residents are encouraged and supported to create a comfortable living space suited to their particular needs and personal	Park Lane Lifecare has fully embedded the Arvida Attitude of Living Well through the wellness/household model. The service has been proactive in implementing the Attitude of Living Well framework within the five pillars (eating well, moving well, resting well, thinking well, and engaging well). In a planned approach, staff create a resident led care environment from a task focussed approach to a relationship-based one reflecting increased choice, autonomy and engagement. The five pillars have created an opportunity for the residents to move away from an institutional care environment to one that enables the resident to determine how their day plays out. At the meetings, resident’s preferences for how they would like to live; environment, routines, freedom of choice, resources, care team approach etc are discussed. Residents have the opportunity to design their model of care. Staff contributed to what they would like if they were residents, and the challenges they faced in providing that, obstacles to be overcome. The outcome of the wellness/household model implementation is that there is a greater acceptance of the model, with significant measurable changes in resident’s wellbeing and interaction. Residents stated that staff have helped

		tastes.	them to feel more engaged and have found ways to meet their personal needs. The resident survey was at 100% overall satisfaction and there were positive comments from residents around having freedom of choice in regards to being able to eat breakfast when it suits them and also feeling more engaged within the village through the wellness programme.
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	CI	There is a quality and risk management system in place at Park Lane Lifecare which is designed to monitor contractual and standards compliance. There is a 2020/2021 business/strategic plan that includes quality goals and risk management plans for Park Lane Lifecare. There is an established culture of seeking to continually review and analyse data to improve resident outcomes.	The service provides an environment that encourages managing and analysing quality data beyond the expected full attainment. The service has conducted a number of quality improvements, including reviewing analysis data to improve resident outcomes. Quality improvements were implemented at the beginning of 2020 around; 1) decreasing the high number of medication incidents, a 46% reduction in medication incidents was made in 2020 (year to date) compared to the same period in 2019, contributing factors to this decrease has been significant increase in medication training for clinical staff, 2) reduction in infection rates for rest home and hospital level of care residents, there have been no outbreaks in 2020 (year to date) compared to three cluster outbreaks in 2019 related to respiratory illness, contributing factors to this decrease has been an increase in infection control staff training, zero tolerance to any unwell staff attending work, reduction in visits from families or friends and outings of residents during Covid-19, 3) reduction of falls for three frequent fallers contributing to 60% of falls during Covid-19 lockdown, initiatives included working with the GP and allied health staff to implement falls prevention strategies, reviewing the roster to ensure adequate supervision of these residents, encouraging resident participation in the activities programme and the use of sensor mats and night lights, as a result these residents reduced falls during the next four month period.
Criterion 1.3.13.1 Food, fluid, and nutritional needs of consumers are provided in line with recognised	CI	All staff at Park Lane assist residents to live the best life they can. The kitchen staff focus on the Eating well model through working alongside residents to design the menu. A quality initiative has been	The residents were strong on voicing their dissatisfaction around the meals and food services. The village manager contracted a consultant to provide a report on all aspects of food preparation, staffing, equipment and plating of meals, and provided the facility with an independent report. Following the report, there was a restructure to include defined roles, improved teamwork and communication.

nutritional guidelines appropriate to the consumer group.		implemented following feedback from residents.	Food forums were commenced, which is an open meeting facilitated by the kitchen manager and the village manager. Up to 50% of resident and family members invited, attend the forum. This is an opportunity to discuss what is going well, not so well, and suggestions for improvement. The food services manager has undertaken moulding training to improve the presentation and plating of puree meals. A wellness expo was held in July 2020, which included tasting tables with take-home recipes of three meal options. As a result of the food forums, the residents suggested they would like an Italian night; a special event to try international foods and cultures. This was provided to all residents. Staff dressed in Italian attire, music was playing, and food and wine was provided. The residents interviewed stated this was highly successful. The food service at Park Lane Lifecare has been named as a finalist in the NZCA/EBOS excellence in care awards. As a result of the food forums and resident input to the menus there has been an increase in the numbers of residents gaining or maintaining their weight in the last 6 months. Sixty-eight percent of residents have gained or maintained weight, with 27% having lost no more than 1.2kgs of weight. Five percent have neither gained nor lost weight.
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	Arvida Park Lane has exceeded the standard by encouraging a team approach around activities and incorporates the living well framework. Wellness partners are involved in the activity programme as part of the living well model. Wellness partners attend household meetings and are involved in the planning, and coordinating activities alongside the wellness team to coordinate the activities the residents would like to attend at a time that suits the residents	The fortnightly household meetings are held with the fourteen residents in each of the three households and two wellness partners. The residents have control of their own budget for leisure and recreation. The wellness leader and the administration team support this by maintaining spreadsheets and corresponding receipts. The residents decide what recreational activities they are going to do. The wellness partners assist with the residents who may be a little reserved. Residents can choose to purchase equipment such as manicure sets, games, and sensory diffusers. Or they can choose to go on trips places including the Lincoln University, to see the Army Band and trips to New Brighton. Having the household meetings and control of the budget empowers residents to make choices in what they do as part of the Wellness model. Minutes of the meetings are maintained, and suggestions are included in the next planner. Some activities are held in the evenings and coordinated by the wellness

			partners (caregivers) such as ‘Mulled wine Mondays’ which has now developed into Springtime Spritzers from 6.30 pm to 7.30 pm. Wednesday night movies, and sensory Fridays, are regular evening activities. The Italian themed night was also coordinated by the wellness partners. As a result of the residents making more decisions around the activities they would like to attend, there has been an increase in the attendance of the chosen activities. The wellness partners (previously more involved with resident cares) are more engaged with the residents. The wellness partners have changed their approach to offer more choices and broadened the holistic approach to support the residents to live well. The satisfaction survey evidenced a 91% satisfaction with activities at Park Lane.

End of the report.