The Abbeyfield (Monifieth) Society Limited
Housing Support Service

Tullis House
6-8 Maule Street
Monifieth
Dundee
DD5 4JN

Telephone: 01382 535 298

Type of inspection:
Unannounced

Completed on:
3 July 2024

Service provided by:
Abbeyfield (Monifieth) Society Limited

Service provider number:
SP2004005848

Service no:
CS2004061233

About the service

The Abbeyfield (Monifieth) Society housing support service is situated in Tullis House in the centre of Monifieth, with easy access to the local shops and services of the town. Tullis House is purpose-built and provides accommodation for 12 people in 10 single rooms and one double room.

All residents have their own room with private use of a shower and toilet. Residents share the use of three kitchens (for breakfast and snack preparation), a dining room, lounge, conservatory, laundry, and gardens. Main meals are prepared in the main kitchen by the housekeeper or the relief housekeeper assistant, and served in the dining room. Out with normal hours, emergency cover is provided by the local authority community alarm service.

At the time of the inspection there were 10 residents living at the service.

About the inspection

This was a full inspection which took place on Wednesday 19 and Thursday 20 June 2024. The inspection was carried out by one inspector from the Care Inspectorate.

To prepare for the inspection we reviewed information about this service. This included previous inspection findings, registration information, information submitted by the service and intelligence gathered since the last inspection.

In making our evaluations of the service we:

- spoke with six people using the service and two of their family representatives;
- spoke with two staff and management;
- observed practice and daily life;
- reviewed documents;
- spoke with visiting professionals.

Key messages

- People living at Tullis House enjoyed a comfortable, well maintained home close to local amenities.
- People were treated with respect and kindness.
- People told us that they felt safe and well looked after.
- Management processes needed to improve.
- Support plan documentation required more detail and to be available to staff and residents.
- Staff training needed to be updated.

From this inspection we evaluated this service as:

In evaluating quality, we use a six point scale where 1 is unsatisfactory and 6 is excellent

How well do we support people's wellbeing?	4 - Good
How good is our leadership?	2 - Weak
How good is our staff team?	3 - Adequate
How well is our care and support planned?	3 - Adequate

Further details on the particular areas inspected are provided at the end of this report.

How well do we support people's wellbeing? 4 - Good

We assessed the service as good in this key question, which means that the service demonstrated a number of important strengths which taken together clearly outweighed areas for improvement.

People living in the service, enjoyed a pleasant homely environment and were treated with kindness and respect. People told us, 'Its great here, I like their motto of promoting independence and independent living, we can come and go as we please' and 'It's easy living here and very pleasant'. We observed respectful interactions between committee members, the housekeeper and residents, and it was clear that familiar and comfortable relationships had developed between each other.

Residents were able to easily access their local community and several people enjoyed the local church singing group and the local shops and services. This is important as it supports people to maintain their independence for as long as possible and ensures that links to the local community are maintained.

The service was not staffed 24 hours, however, residents were supported overnight with community alarm for emergencies.

Support plans did not contain adequate information about the supports that other professionals provided or the frequency of their visits. This increased risks for people as staff may not be fully aware of who, or when to contact other involved professionals if needed. Some improvements had been made to the initial baseline information in support plans, such as information relating to next of kin (NOK) and contact information of other professionals involved in people's support. We made a requirement at our last inspection which we have extended to allow more time for service to improve in this area. **(See 'What the service has done to meet requirements we made at or since the last inspection', and section two of this report, 'How good is our leadership').**

Residents enjoyed freshly prepared meals, with lunches and the evening meals provided and shared in the communal dining room. People told us that they enjoyed the meals provided and told us, 'the food is good' and 'we are well catered for here'. Fresh fruit and snacks were available in the communal areas and tea, coffee, milk and bread were re-stocked regularly in the shared kitchenettes. Although the meals were fresh and appetising the housekeeper had not received specific training in the provision of specialist diets. Some people who required specific meal choices, for example, those who required diabetic diets, told us that they were not always catered for adequately, and there was a lack of understanding of people's requirements in respect of these diets. The service should ensure that staff have the appropriate knowledge and skills to maintain peoples dietary health and wellbeing. **(See requirement 1 in section three of this report, 'How good is our staff team').**

During our inspection residents and some relatives enjoyed a talk and slide show from a visitor, however, some residents told us that the afternoons and evenings were long with few opportunities for social interactions. We heard that there used to be more activities, such as games and film nights, and some exercise classes but people had stopped attending. Several new people had recently moved into Tullis house, who told us that they would like more social opportunities. We discussed with the committee the importance of regularly reviewing this with people living at the service to ensure that opportunities were available for people who would benefit from this support. It was good to see that key events were celebrated together over the course of the year; such as Christmas, Easter and Valentines, and that

occasional talks from external sources were provided and enjoyed. We will follow this area up at our next inspection.

How good is our leadership? 2 - Weak

We assessed this quality theme as weak. An evaluation of weak will apply to performance in which strengths can be identified but these are outweighed or compromised by significant weaknesses.

People using the service, and relatives told us that the committee members were available to them if they needed to discuss any concerns, and that they were approachable and friendly. One person told us, 'My relative has been made very welcome since they arrived, and the committee was proactive in helping them to settle in,' and another told us 'we are very well cared for here'.

We observed kind and respectful interactions between committee members and residents during the course of our inspection, with committee members visible in the service and working hard to ensure that people had a good experience.

Management of the service was undertaken by a committee of volunteers; however, collectively they did not have relevant knowledge or experience of managing a housing support service. This meant that some important requirements of managing a support service had not been carried out to the standards expected. For example, formal stakeholder and resident engagement had not been carried out for some time, which meant there were few opportunities for people to give feedback about the service and what was important to them. Committee meetings were held monthly, however, minutes of these meetings were not shared unless there had been tenant representation at the meeting, which had not occurred for some time. We heard that the committee had asked for resident representation to attend meetings in the past, however, more recently this had been unsuccessful. We discussed the importance of reviewing this regularly and providing alternative methods to ensure that people had opportunities to be involved and kept updated about the service.
(See area for improvement 1).

We asked that the committee carry out a training needs analysis following our last inspection, in order to support a shared understanding of how to carry out their roles more effectively. However, this had not been done and some essential training needs were outstanding. Some training around adult support and protection had been completed; however, members were either unaware of all their training needs, or were unable to prioritise this. This meant that there were gaps in their knowledge and understanding which impacted on all areas of the service.
(See the section, 'What the service has done to meet requirements at or since our last inspection', and requirement 1 which we have extended to allow more time to improve this area).

Support plans, including risk assessments were completed by the committee. These had been improved with the addition of more detailed baseline information about people, and were linked to the 'Health and Social Care Standards'. However, documents were incomplete, or lacked essential information important in ensuring that people were safe and properly represented. For example, risk assessments did not contain enough information for staff to be clear about the level of risk for individuals to keep people safe, reviews had not been carried out at six monthly intervals as is required of all services and they did not clearly set out who had been invited to these meetings. We heard about some work that had been carried out to improve outcomes for some individuals, however, this work was undocumented and had not been described or

referred to in support plans or risk assessments. The committee needed to improve their audits and oversight of these core processes to ensure these were completed.
(See the section, 'What the service has done to meet requirements at or since our last inspection', and requirement 1 which we have extended to allow more time to improve this area).

Some work to improve the recording and notification of accidents and incidents had been made. The service had introduced an accident and incident book, however, there were lapses in recording or reporting. There was a lack of understanding of what information was required, the detail and what was required to be reported to the Care Inspectorate. This meant that we could not be confident that the committee fully understood their responsibilities in reporting and accurately recording these incidents.
(See the section, 'What the service has done to meet requirements at or since our last inspection', and requirement 2 which we have extended to allow more time to improve this area).

Other core processes such as staff support and oversight were incomplete. Quality assurance audits were limited to kitchen cleanliness and food hygiene and had not always been completed at the correct intervals. The service did not have a development plan which could have supported the committee to ensure that improvements to the service were carried out meaningfully and measurably. We discussed ways in which the service could improve, and have extended and continued the time for previous requirements to be met.

Requirements

1. By 03 January 2025, the provider must ensure that service users experience a service which is managed in a manner which results in better outcomes for service users through a culture of continuous improvement, underpinned by robust and transparent quality assurance processes.

This must include but is not limited to:
a) ensuring appropriate and effective leadership of the service;
b) ensuring that service users' assessed support needs are monitored, managed and reviewed at six monthly intervals;
c) implement effective action planning to address areas of required improvement to include appropriate timescales for completion and review of actions to be undertaken, and ensuring staff are accountable for and carry out the required remedial actions.
d) ensure that a training needs analysis of all committee members and staff is carried out to ensure that staff have the skills necessary to keep people safe.

This is to comply with:
The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 SSI 2011/210 Regulation 3 - Principles & Regulation 4. 1 (a) Welfare of Users.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that:
'I benefit from a culture of continuous improvement, with the organisation having robust and transparent quality assurance processes.' (HSCS 4.19)

2. By 31 July 2024, the provider must ensure that the Care Inspectorate is notified of accidents and incidents promptly, as per guidance 'Records that all registered care services (except childminding) must keep and guidance on notification reporting'

This is to comply with The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations SSI 2011/210, regulation 4(1)(a). Health, welfare and safety of service users

This is to ensure care and support is consistent with Health and Social Care Standards (HSCS) which state that,
'I benefit from different organisations working together and sharing information about me promptly where appropriate' (HSCS 4.18).

Areas for improvement

1. In order to ensure that people have opportunities to feedback about the service and be involved in supporting improvement, it is recommended that the service carry out a service user satisfaction survey to obtain the views of people using the service, and consider a variety of ways in which consultation and involvement of people using the service could be encouraged and supported.

This is to ensure care and support is consistent with Health and Social Care Standards (HSCS) which state that,
'I am actively encouraged to be involved in improving the service I use, in a spirit of genuine partnership' (HSCS 4.7)
'I am supported to give regular feedback on how I experience my care and support and the organizations uses learning from this to improve' (HSCS 4.8)

How good is our staff team? 3 - Adequate

We assessed this key question as adequate. An evaluation of adequate applies where there are some strengths but these just outweigh weaknesses. Strengths may still have a positive impact but the likelihood of achieving positive experiences and outcomes for people is reduced significantly because key areas of performance need to improve.

Staff worked well together with the committee members and created a warm and homely atmosphere in the service. People using the service and relatives told us that the staff and committee members were always respectful and went out of their way to make them feel safe and at home. We heard that staff communicated appropriately with relatives when this was required and that they had confidence in the staff. Family members told us 'they let me know if there are any concerns about my relative'. This provided reassurance to family members who couldn't always be available to people living in the service.

There were sufficient numbers of staff to support people to ensure that the core functions of the service were carried out and that service was clean and well maintained.

Staff supervision had not been carried out in accordance to the service's own policies. Staff we spoke with told us, 'I don't get supervision but I do have an annual appraisal. The committee are fine if I have any problems that I need to discuss' and 'the committee members were always available to discuss any concerns, and we have a meeting once every two months' . Staff felt supported and did have access to regular update meetings, however, supervision of staff needed to improve. We found that some areas relating to practice had been discussed during appraisal, however, had not been discussed during

supervision at the time. This meant there was no record of how these matters had been managed to ensure that any practice concerns were addressed formally.
(See section 'What the service has done to meet areas for improvement at or since our last inspection' and area for improvement 1, which we have re-stated and extended to allow more time to improve this area).

All relevant staff and one of the committee members had received protection of vulnerable adults training since our last inspection. This had been identified as a training need and it was good to see that this had been put in place and completed. One of the committee members cascaded this training to the remaining committee members. This is important to ensure that staff have the skills to identify if people are at risk and know how to report concerns to the appropriate authorities.

Some staff training such as first aid and food hygiene required to be updated. Dates had not been organised for this training at the time of this inspection and we reminded staff and committee members of the importance of ensuring that essential training is kept up to date. None of the staff had undertaken infection prevention and control (IPC) training. IPC is a key training area for all services to ensure that staff are knowledgeable and understand their responsibilities in ensuring why and how to keep the environment clean and safe.

Some tenants required additional support to manage their dietary needs as a result of diabetes. We found that staff had not received specific training and support to ensure that they were able to meet the needs of people in these circumstances. We discussed this with the committee, who agreed that they would ensure that this was completed as priority.
(See requirement 1).

Staff had not been recruited following the guidance, 'Safer recruitment, better recruitment'. Some areas had been missed, such as obtaining references for new employees and ensuring that new staff had received adequate induction and supervision at the start of their employment. This meant we did not have confidence that new staff had been recruited safely, or that checks had been made to ensure that new staff understood their roles and responsibilities.
(See the section 'What the service has done to meet requirements we made at or since the last inspection' and requirement 2. We have extended this requirement to allow more time for the service to improve this area).

Requirements

1. By 03 January 2025 the provider must ensure that all staff training requirements are up to date.

This should include, but is not limited to:
a) Complete updates for all core and essential training such as food hygiene, Infection and prevention control training and first aid.
b) Ensure that relevant staff receive training regarding supporting dietary requirements of residents including diabetic diets.

This is to comply with:
The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 SSI 2011/210 Regulation 3 - Principles & Regulation 4. 1 (a) Welfare of Users.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that,
'I experience high quality care and support based on relevant evidence, guidance and best practice.' (HSCS 4.11)

2. By 31 July 2024, the provider must ensure that when it recruits staff, it follows the guidance in "Safer Recruitment Through Better Recruitment" (Scottish Government, 2016). This will help to ensure that all staff who are employed in the care home are fit to work with vulnerable people.

This is in order to comply with:
The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011(SSI 2011/210)Regulation 4(1)(a), 9(1)(2) - fitness of employees

This is to ensure care and support is consistent with Health and Social Care Standards (HSCS) which state that,
'I benefit from different organisations working together and sharing information about me promptly where appropriate, and I understand how my privacy and confidentiality are respected (HSCS 4.18)

Areas for improvement

1. In order to support staff, and in accordance to the service own policies, it is recommended that the provider carries out supervision of staff at intervals stated in the service's own policies and procedures.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that,
'I have confidence in people because they are trained, competent and skilled, are able to reflect on their practice and follow their professional codes.' (HSCS 3.14).

How well is our care and support planned? 3 - Adequate

We assessed this key question as adequate. An evaluation of adequate applies where there are some strengths but these just outweigh weaknesses. Strengths may still have a positive impact but the likelihood of achieving positive experiences and outcomes for people is reduced significantly because key areas of performance need to improve.

Support plans had recently improved to include information regarding next of kin details and a record where people had legal representation such as power of attorney's (POA) in place. However, this information had not been completed fully to include the powers that people held to ensure that they were represented correctly, and by the right person when required.
(See section 'What the service has done to meet areas for improvement at or since our last inspection' and area for improvement 1, which we have extended to allow more time to improve this area).

Support plans had been updated to include more information about other professionals involved in providing people's support. This included input from district nurses and other health practitioners. However, where people's health needs had changed, information had not been updated in support plans which meant that

people were at risk of not receiving care and support to meet their changing needs. For example, one person had recently become diabetic but the support plan had not been updated to reflect this or information on how this should be managed. In addition some people had' do not attempt cardio pulmonary resuscitation' (DNACPR) documents in support plans, however, these were not available at the point of need. We reminded the committee that support plans and key documents such as DNACPR forms must be up to date and accessible to people in their own rooms so that emergency services can see and access them if required. **(See area for improvement 1).**

Some risk assessments were in place, however, these were either not fully completed or did not have enough information to inform staff of the level of risk or how to reduce it. Further work was required to ensure that support plans were updated and reviews carried out at six monthly intervals to ensure that support was consistent with the stated outcomes that people wanted to achieve. We have continued a previously stated requirement to allow the service more time to ensure that support plans were up to date and fully completed.
(See section 'What the service has done to meet requirements at or since our last inspection' and requirement 1 in the section two, 'how good is our leadership, which we have re-stated and extended to allow more time to improve this area).

Areas for improvement

1. In order to ensure that people are are fully represented, the service should ensure that records are updated to include information about people's legal representatives. These should include;
a) the legal powers that they hold;
b) when these powers should be enacted;
c) ensure that relevant people are invited to reviews and updates relating to the powers that they hold.

This to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which states that,
'If I am unable to make my own decisions at any time. the views of those who know my wishes, such as my carer, independent advocate, formal or informal representative, are sought and taken into account' (HSCS 2.12).

2. In order to ensure that people's health and wellbeing are managed and staff have the right information at the right time; the manager should ensure that support plans are updated when health needs change, and that DNACPR documentation is available to emergency services at the point of need.

This to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which states that,
'My care and support is provided in a planned and safe way, including if there is an emergency or unplanned event.' (HSCS 4.14).

What the service has done to meet any requirements we made at or since the last inspection

Requirements

Requirement 1

By 1 November 2023, the provider must ensure that service users experience a service which is managed in a manner which results in better outcomes for service users through a culture of continuous improvement, underpinned by robust and transparent quality assurance processes. This must include but is not limited to:

a) ensuring appropriate and effective leadership of the service;
b) ensuring that service users' assessed support needs are monitored, managed and reviewed at six monthly intervals;
c) implement effective action planning to address areas of required improvement to include appropriate timescales for completion and review of actions to be undertaken, and ensuring staff are accountable for and carry out the required remedial actions.
d) ensure that a training needs analysis of all committee members and staff is carried out to ensure that staff have the skills necessary to keep people safe.

This is to comply with:

The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 SSI 2011/210 Regulation 3 - Principles & Regulation 4. 1 (a) Welfare of Users.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that:
'I benefit from a culture of continuous improvement, with the organisation having robust and transparent quality assurance processes.' (HSCS 4.19)

This requirement was made on 31 May 2023.

Action taken on previous requirement

Some work has progressed since the last inspection, which relates to improved baseline documentation of the initial support plan. All residents now have this new documentation in place, which provides more comprehensive information regarding details of some health issues, relatives and other professional support. However, this information was incomplete and had not been updated when people's health needs had changed.

Reviews of support plans have not been done at 6 monthly intervals as required of all services and did not represent the views of residents involved.

Risk assessments have not been completed fully, or reviewed to ensure that risks have been properly explained or reduced.

Some staff training has taken place relating to adult support and protection training, however, none of the

staff or committee have undertaken IPC training updates, which was discussed at the previous inspection, and some first aid training and food hygiene training for some staff required updating.

This requirement has not been met and we have agreed to an extension until 3 January 2025 to allow more time for the service to improve in this area.

Not met

Requirement 2

With immediate effect, the provider must ensure that when it recruits staff, it follows the guidance in "Safer Recruitment Through Better Recruitment" (Scottish Government, 2016). This will help to ensure that all staff who are employed in the care home are fit to work with vulnerable people.

This is in order to comply with:
The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011(SSI 2011/210)Regulation 4(1)(a), 9(1)(2) - fitness of employees

This is to ensure care and support is consistent with Health and Social Care Standards (HSCS) which state that, 'I benefit from different organisations working together and sharing information about me promptly where appropriate, and I understand how my privacy and confidentiality are respected (HSCS 4.18).

This requirement was made on 31 May 2023.

Action taken on previous requirement
One new member of staff had been appointed since the last inspection. Although it was good to see that the staff member had not started in the service before a PVG certificate had been issued, we found that other areas of safer recruitment had not been completed. The application form was incomplete, and references had not been taken up by previous employers. In addition, there was no evidence of staff induction or supervision, which meant it was unclear if the staff member had received adequate checks and support to fulfil their roles fully.

This requirement has not been met and we have agreed to an extension until 31 July 2024 to allow more time for the service to improve in this area.

Not met

Requirement 3

With immediate effect, the provider must ensure that the Care Inspectorate is notified of accidents and incidents promptly, as per guidance 'Records that all registered care services (except childminding) must keep and guidance on notification reporting'

This is to comply with The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations SSI 2011/210, regulation 4(1)(a). Health, welfare and safety of service users

This is to ensure care and support is consistent with Health and Social Care Standards (HSCS) which state that,
'I benefit from different organisations working together and sharing information about me promptly, where appropriate' (HSCS 4.18).

This requirement was made on 31 May 2023.

Action taken on previous requirement

Accidents and incident books had been put in place; however, it was clear that staff were not confident about the level of information that was required, or of what should be reported. For example, we found one incident was recorded in an incident report, but there was scant information which did not provide enough detail of whether this should have been reported as a notification to the Care Inspectorate. We also received notification of another incident, which had not been reported in the incident book.

Further work to fully understand the notification guidance is required and guidance has been shared with the committee members.

This requirement has not been met and we have agreed to an extension until 31 July 2024 to allow more time for the service to improve in this area.

Not met

What the service has done to meet any areas for improvement we made at or since the last inspection

Areas for improvement

Previous area for improvement 1

It is recommended that the provider carries out supervision of staff at intervals stated in the service's own policies and procedures.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that,
'I have confidence in people because they are trained, competent and skilled, are able to reflect on their practice and follow their professional codes.' (HSCS 3.14).

This area for improvement was made on 31 May 2023.

Action taken since then

Staff had not received any supervision since our last inspection. An annual appraisal was carried out; however, these did not take forward areas of development, or address other areas of development highlighted for staff in staffing files.

This area of improvement is not met and has been re-instated.

Previous area for improvement 2

In order to ensure that people are fully represented, the service should ensure that records are updated to include information about people's legal representatives.

These should include;
a) the legal powers that they hold;
b) when these powers should be enacted;
c) ensure that relevant people are invited to reviews and updates relating to the powers that they hold.

This to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which states that,
'If I am unable to make my own decisions at any time. the views of those who know my wishes, such as my carer, independent advocate, formal or informal representative, are sought and taken into account' (HSCS 2.12).

This area for improvement was made on 31 May 2023.

Action taken since then

Some work to progress in this area had taken place, and the new support plan information did indicate if a resident had a power of attorney in place. However, more information was required detailing the powers that POAs held to ensure that powers were being used appropriately. Reviews were not being carried out at six monthly intervals and it was not evident in review documentation that POAs had been invited. When we spoke to one POA they also informed that they had not been invited to these meetings.

This area for improvement has not been met and has been re-instated.

Complaints

There have been no complaints upheld since the last inspection. Details of any older upheld complaints are published at www.careinspectorate.com.

Detailed evaluations

How well do we support people's wellbeing?	4 - Good
1.3 People's health and wellbeing benefits from their care and support	4 - Good

How good is our leadership?	2 - Weak
2.2 Quality assurance and improvement is led well	2 - Weak

How good is our staff team?	3 - Adequate
3.1 Staff have been recruited well	3 - Adequate
3.2 Staff have the right knowledge, competence and development to care for and support people	3 - Adequate
3.3 Staffing arrangements are right and staff work well together	4 - Good

How well is our care and support planned?	3 - Adequate
5.1 Assessment and personal planning reflects people's outcomes and wishes	3 - Adequate

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Care Inspectorate
Compass House
11 Riverside Drive
Dundee
DD1 4NY

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