

Radius Residential Care Limited - Radius Peppertree Care Centre

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

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

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

The specifics of this audit included:

Legal entity: Radius Residential Care Limited

Premises audited: Radius Peppertree Care Centre

Services audited: Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

Dates of audit: Start date: 13 February 2017 End date: 14 February 2017

Proposed changes to current services (if any): This audit has assessed the service as suitable to provide residential disability (physical) level of care.

Total beds occupied across all premises included in the audit on the first day of the audit: 62



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

Radius Peppertree is owned and operated by Radius Residential Care Limited. The service provides care for up to 62 residents requiring rest home or hospital (medical/geriatric) level care. This audit has also verified the service as suitable to provide residential disability (physical) level of care. On the day of the audit, there were 62 residents. An enrolled nurse (who no longer maintains a practicing certificate); with experience in aged care management manages the service. A Radius regional manager and a clinical manager support her. Residents and relatives interviewed spoke positively about the service provided, particularly around the positive culture and the value placed on each resident.

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

The service has exceeded the standard around management of complaints, staff education, activities, and the external environment.

This audit has not identified any areas requiring improvement.

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.

Policies and procedures adhere with the requirements of the Code of Health and Disability Services Consumers' Rights (the Code). Residents and families are informed regarding the Code and staff receive ongoing training about the Code.

Personal privacy and values of residents are respected. There is an established Māori health plan in place. Individual care plans reference the cultural needs of residents. Discussions with residents and relatives confirmed that residents and where appropriate their families are involved in care decisions. Regular contact is maintained with families including if a resident is involved in an incident or has a change in their current health. Families and friends can visit residents at times that meet their needs. Examples of good practice were provided.

There is an established system for the management of complaints, which meets guidelines established by the Health and Disability Commissioner.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.

Standards applicable to this service fully attained.

A facility manager and clinical manager are responsible for day-to-day operations. Goals are documented for the service with evidence of regular reviews. A quality and risk management programme is embedded in practice. Results are shared with staff.

Corrective actions are implemented and evaluated where opportunities for improvements are identified. Residents receive services from suitably qualified staff. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. An education and training plan is being implemented and includes in-service education and competency assessments. Registered nursing cover is provided 24 hours a day, 7 days a week.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		All standards applicable to this service fully attained with some standards exceeded.
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Primarily the clinical manager manages entry to the service. There is comprehensive service information available. A registered nurse completes initial assessments. The registered nurses complete care plans and evaluations within the required timeframes. Care plans are written in a way that enables all staff to clearly follow their instructions. Wound documentation is comprehensive. Residents and family interviewed confirmed they were involved in the care planning and review process.

Each resident has access to individual, group and small group activity programmes that meets the recreational needs of the residents, including younger residents.

Medication is managed in line with legislation and guidelines. Staff have had education around medication management and all staff who administer medications have completed a competency assessment. Medications are stored, prescribed and administered in line with appropriate guidelines and regulations. General practitioners review residents at least three monthly or more frequently if needed.

Meals are prepared on site. The menu is varied and appropriate. Individual and special dietary needs are catered for. Alternative options can be provided. Residents and relatives interviewed were complimentary about the food service.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.

Standards applicable to this service fully attained.

The building has a current warrant of fitness and emergency evacuation plan. There is an approved evacuation scheme and emergency supplies for at least three days. Ongoing maintenance issues are addressed. Chemicals are stored safely throughout the facility. All bedrooms are single occupancy. There is an adequate number of communal showers and toilets. There is sufficient space to allow the movement of residents around the facility using mobility aids. There are lounges and dining areas in different areas of the facility. The internal areas can be ventilated and heated. The outdoor areas provide seating and shade and have been improved in response to resident feedback. Cleaning and maintenance staff are providing appropriate services.

There is an emergency management plan in place and adequate civil defence supplies in the event of an emergency. There is an approved evacuation scheme and emergency supplies for at least three days.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.

Standards applicable to this service fully attained.

Staff receive training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. The restraint coordinator maintains a register. During the audit, three residents were using restraints and two residents were using enablers. Staff regularly receive education and training in restraint minimisation and managing challenging behaviours.

Infection prevention and control

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

Standards applicable to this service fully attained.

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. 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.

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	2	48	0	0	0	0	0
Criteria	4	97	0	0	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Radius Peppertree Care Centre policies and procedures are being implemented that align with the requirements of the Code of Health and Disability Services Consumers' Rights (the Code). Families and residents are provided with information on admission, which includes information about the Code. Staff receive training about resident rights at orientation and as part of the annual in-service programme. Interviews with eight care staff (five caregivers across the am and pm shifts, two registered nurses (RN) and one diversional therapist) confirmed their understanding of the Code. Nine residents (four hospital and five rest home level) and six relatives (three hospital and three rest home) interviewed confirmed that staff respect privacy and support residents in making choices.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed</p>	FA	<p>Informed consent processes are discussed with residents and families on admission. The resident or their EPOA signs written consents. Advanced directives are signed for separately. There is evidence of discussion with family when the GP completed a clinically indicated not for resuscitation order. Healthcare assistants and registered nurses interviewed confirmed verbal consent is obtained when delivering care. Discussion with family members identified that the service actively involves them in decisions that affect their relative's lives.</p> <p>Eight of eight resident files sampled (three rest home including one resident on a younger person's contract and five hospital including one resident on a younger person's contract) had a signed admission agreement</p>

consent.		and consents.
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	Residents interviewed confirmed they are aware of their right to access independent advocacy services. Discussions with relatives confirmed the service provided opportunities for the family/EPOA to be involved in decisions. The resident files sampled included information on residents' family/whānau and chosen social networks. The Nationwide Health and Disability Advocacy service is an invited speaker at resident/family meetings and staff training on the Code and the role of advocacy services.
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. The service is responsive to young people with disabilities accessing the community, resources, facilities and mainstream supports such as education, public transport and primary health services in the community. The activities programme includes opportunities to attend events outside of the facility. Relatives and friends are encouraged to be involved with the service and care.
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	CI	There is a policy to guide practice, which aligns with Right 10 of the Code. The facility manager leads the investigation of non-clinical and clinical concerns/complaints in consultation with the regional manager/RN. All concerns and complaints are entered into an on-line complaints register. The service identified a project to reduce complaint numbers and the response to issues has exceeded the required standard. There were no complaints made in 2016 and one complaint received to date for 2017. Appropriate action has been taken within the required timeframes and to the satisfaction of the complainants. Complaints forms are visible in the main entrance. Management operate an 'open door' policy. Families and residents interviewed confirm they are aware of the complaints process and that management are approachable. The complaints procedure is provided to residents in the information pack on entry.
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	There is an information pack given to prospective residents and families that includes information about the Code and the nationwide advocacy service. There is the opportunity to discuss aspects of the Code during the admission process. Residents and relatives interviewed confirmed that information had been provided to them around the Code. Large print posters of the Code and advocacy information are displayed throughout the facility. A manager discusses the information pack with residents/relatives on admission. Families and residents are informed of the scope of services and any liability for payment for items not included in the

		scope. This is included in the service agreement.
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>A tour of the premises confirmed there were areas that support personal privacy for residents. During the audit staff were observed to be respectful of residents' privacy by knocking on doors prior to entering resident rooms. Young people with disabilities can maintain their personal, gender, cultural, religious and spiritual identity. Care staff interviewed could describe definitions around abuse and neglect that aligned with policy. Residents and relatives interviewed confirmed that staff treat residents with respect. Resident preferences are identified during the admission and care planning process and this includes family involvement. Interviews with residents confirmed their values and beliefs were considered. Interviews with caregivers described how choice is incorporated into resident cares.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>The Māori health plan policy for the organisation references local Māori healthcare providers regionally within New Zealand and provides recognition of Māori values and beliefs. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. Links are established with disability and other community representative groups as requested by the resident/family. During the audit, there were no residents that identified as Māori.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>An initial care planning meeting is carried out where the resident and/or whānau as appropriate are invited to be involved. Six-monthly multidisciplinary team meetings occur to assess if needs are being met. Family are invited to attend. Discussions with relatives confirmed that residents' values and beliefs are considered. Residents interviewed confirmed that staff consider their values and beliefs.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from</p>	FA	<p>Staff job descriptions include responsibilities. The monthly staff meetings include discussions around professional boundaries and concerns as they arise. Management provided guidelines and examples of mentoring for specific situations. Interviews with the managers and care staff confirmed their awareness of</p>

any discrimination, coercion, harassment, sexual, financial, or other exploitation.		professional boundaries.
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>Policies and procedures are aligned with current accepted best practice. The content of policy and procedures are sufficiently detailed to allow effective implementation by staff. An annual in-service training programme is implemented as per the training plan, with training for RNs from the district health board (DHB). Outcomes for the service are monitored with benchmarking across all Radius facilities. Feedback is provided to staff via the various meetings and through graphs and notices on the noticeboard in the staff room. There is a minimum of one RN on the night shift with two RNs on the am and pm shifts. A physiotherapist is available two hours a week. Registered nurses and caregivers were described by residents and family as being caring.</p> <p>The service has created a culture that is resident centred. Residents interviewed and their families described that the residents are the centre of all things that happen at Peppertree. All residents interviewed felt that they played a significant role in the life of the Peppertree 'family' and that their presence at the home was valued.</p> <p>A culture of continual improvement has been adopted by leadership and staff, with any suggestion from staff, family, residents or community members being viewed as an opportunity to improve the outcomes and satisfaction of those who reside at the service.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>There is a policy to guide staff on the process around open disclosure. Accident/incident forms have a section to indicate if family have been informed of an accident/incident. Incident forms reviewed identify that family have been notified following resident incidents. The clinical manager and facility manager advised that family are kept informed and this was confirmed on interview with three hospital residents' family members. Two monthly resident meetings are held. Resident meetings provide residents with an opportunity to feedback on the services provided and ensure they are kept informed on facility matters. Residents and relatives receive a facility newsletter every two months and this and other initiatives around communication have exceeded the required standard. There is access to interpreter services.</p> <p>A range of data relating to complaints, incidents, accidents, health and safety, risk management and internal audit reports is used to improve the service. Projects are undertaken where opportunities for improvements are identified. A quality initiative was implemented in August 2015 around communication to and with residents to be improved to ensure they are well informed and part of the decision-making process. Monthly meetings are held at regular intervals to communicate quality initiatives and outcomes.</p> <p>The resident/relative satisfaction survey in 2014 indicated that communication within the service did not meet</p>

		<p>the expected satisfaction of residents and families. Over the past three years (January 2014 to December 2016) the service has introduced resident newsletters, an open-door policy for residents and families, provided more education for staff, and commenced staff newsletters. The newsletters were established for better communication and information about what's happening/happened and providing general information. Use of email to residents and families to communicate with them and keep them informed. Two monthly resident meetings provide residents with an opportunity to feedback on the services provided and ensure they are kept informed on facility matters.</p> <p>The facility manager has completed a Transformational Leadership Programme course through the local district health board. This programme aims to transform leaders to achieve higher levels of performance and satisfaction, empower and stimulate staff to exceed normal levels of performance. Communication is the key aspect of Transformational Leadership. Staff have better knowledge and skills through the additional education with the consumer code of rights, communication and the provision of care to meet the needs of the residents. Families communicate more openly and feel confident that they can work with management to resolve any issues.</p> <p>Because of these initiatives, satisfaction with communication with residents and families improved from 20% in 2014 to 66% in 2016. Peppertree achieved the 2nd highest occupancy in 2015 and the highest occupancy in 2016 throughout Radius facilities.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Radius Peppertree provides rest home and hospital level of care for up to 62 residents. There are 20 rest home beds, 20 dual-purpose beds (located within the 'rest home' wing) and 22 hospital level beds. On the day of audit, there were 27 rest home level and 35 hospital level residents, including 13 hospital residents in the dual-purpose beds. There were four hospital and one rest home level residents on younger persons with disabilities contracts. This audit has also verified the service as suitable to provide residential disability (physical) level of care. All other residents were under the ARCC. There were no residents under the medical component or on respite care at the time of the audit.</p> <p>Radius has an organisational philosophy, which includes a vision and mission statement. There is a strategic business plan for April 2014 to March 2017 that has had an annual review. Ongoing goals are reviewed regularly. The facility manager (previously an enrolled nurse) has been in the role three and a half years and has experience in aged care management. A clinical manager/RN appointed in September 2014 supports her. The clinical manager has had clinical experience within the DHB and the aged care environment. A regional manager visits the service on a regular basis.</p> <p>The facility manager has maintained at least eight hours annually, of professional development related to managing an aged care facility.</p>

<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>The clinical manager covers during the temporary absence of the facility manager. For extended absences, Radius has interim (roving) facility managers who cover facility manager absences. The regional manager is available on a consultative basis.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>An established quality and risk management system is embedded into practice. Quality and risk performance is reported across facility meetings and to the regional manager. Discussions with the managers (regional manager, facility manager, clinical manager/RN) and care staff, reflected staff involvement in quality and risk management processes. Young people with disabilities have input into quality improvements to the service with examples provided. Satisfaction with choices, decision making, access to technology, aids equipment and services contribute to quality data collected by the service.</p> <p>Resident and family meetings are held each month. Minutes are maintained. Annual resident and relative surveys were completed in July 2016. Results were collated and discussed with staff. Corrective actions have been implemented and signed off. The service has policies and procedures and associated implementation systems, adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. The service's policies are reviewed at a national level by the clinical managers group with input from facility staff every two years. Clinical guidelines are in place to assist care staff. Updates to policies included procedures around the implementation of InterRAI and health and safety to the new Act.</p> <p>The quality monitoring programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility and across the organisation. There are clear guidelines and templates for reporting. The facility has implemented established processes to collect, analyse and evaluate data, which is utilised for service improvements to a standard that exceeds the requirements. Results are communicated to staff in meetings and on staff noticeboards. Corrective action plans are implemented when opportunities for improvements are identified (eg, internal audit results are lower than 95%). Corrective actions are evaluated and signed off when completed.</p> <p>Health and safety policies are implemented and monitored by the health and safety committee. The health and safety representative (maintenance person) was interviewed about the health and safety programme. Health and safety representatives have completed external health and safety training. Risk management, hazard control and emergency policies and procedures are in place. There are procedures to guide staff in</p>

		<p>managing clinical and non-clinical emergencies. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Radius has achieved tertiary level ACC WSMP (expiry 31 July 2018).</p> <p>As a result of data analysis completed on falls, the facility has implemented a number of quality improvements. Falls prevention strategies include: manual handling refresher education for all care staff, ensuring transfer plans are current, intentional rounding, use of senior mats, analysis of falls events including times and location of falls and links to any infection/period of illness and the identification of interventions on a case-by-case basis to minimise future falls.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Fifteen accident/incident forms for the month of January 2017 were reviewed. There has been RN notification and clinical assessment completed in a timely manner. Accidents/incidents were recorded in the resident progress notes. There is documented evidence that family/whānau had been notified. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Trending data is considered. Discussions with the regional manager and facility manager confirm an awareness of the requirement to notify relevant authorities in relation to essential notifications.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Human resources policies include recruitment, selection, orientation and staff training and development. Eight staff files reviewed (one facility manager, one clinical manager, one RN, three caregivers, one kitchen manager and one activities coordinator) included a recruitment process (interview process, reference checking, police check), signed employment contracts, job descriptions and completed orientation programmes. Performance appraisals were up-to-date in all eight staff files reviewed. A register of registered nursing staff and other health practitioner practising certificates is maintained.</p> <p>The orientation programme provides new staff with relevant information for safe work practice. There is an implemented annual education and training plan that exceeds eight hours annually. All staff participate in continuing education relevant to physical disability and young people with physical disabilities. There is an attendance register for each training session and an individual staff member record of training. Staff are required to complete written core competencies during their induction. These competencies are repeated annually.</p> <p>Registered nurses are supported to maintain their professional competency. Five out of ten registered nurses have completed their InterRAI training. There are implemented competencies for registered nurses</p>

		including (but not limited to) medication competencies and insulin competencies.
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. A roster provides sufficient and appropriate coverage for the effective delivery of care and support. The roster can be increased depending on the needs of residents. There are two RNs (one in the rest home and one in the hospital) on morning and afternoon shifts and one RN on night duty to cover both areas, with three caregivers. The facility manager and clinical manager are on-site Monday to Friday with shared on call. The caregivers, residents and relatives interviewed inform there are sufficient staff on duty at all times.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The residents' files were appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents' files are protected from unauthorised access. Entries are legible, dated and signed by the relevant caregiver or nurse including designation. Progress notes in the residents' files were lacking service integration. A locked room stores archived residents' files.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>The service has comprehensive admission policies and processes in place. Residents receive an information pack outlining services able to be provided, the admission process and entry to the service. The clinical manager screens all potential residents prior to entry and records all admission enquiries. Residents and relatives interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the facility manager. The admission agreement form in use aligns with the requirements of the ARC contract. Exclusions from the service are included in the admission agreement. The information provided at entry includes examples of how services can be accessed that are not included in the agreement.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or</p>	FA	<p>There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs. Relatives interviewed confirmed they were kept well informed about all matters pertaining to residents, especially if there is a change in the resident's condition.</p>

transfer from services.		
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>The medication management policies and procedures comply with medication legislation and guidelines. Medicines are appropriately stored in accordance with relevant guidelines and legislation. Registered nurses are responsible for the administration of medications and they complete an annual medication competency and attend medication education annually. Medication prescribed is signed as administered on the pharmacy generated signing chart. The RN on duty reconciles the delivery and documents this on the signing sheet. There were no self-medicating residents on the day of audit. Standing orders are not used. Medical practitioners write medication charts correctly and there was evidence of one to three monthly reviews by the GP. All 16 medication charts reviewed had photo identification and allergy status identified.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The service employs a kitchen manager and two other cooks. Kitchenhands support the cooks. All staff have attended food safety hygiene training and chemical safety.</p> <p>There is a fully functional kitchen and all meals and baking is prepared and cooked on site. A food services manual is in place to guide staff. The cooks follow a rotating seasonal menu, which has been reviewed by the company dietitian. All recipes are readily accessible through the organisational intranet. Meals are served directly to residents in the dining rooms, from the kitchen and they are delivered in hot boxes to the other dining areas and rooms. The service has exceeded the required standard around ensuring all meals, snacks and drinks are served at the temperature preferred by the residents. A resident nutritional profile is developed for each resident on admission and is provided to the kitchen staff. The kitchen manager (interviewed) is notified of any dietary changes. Resident likes, dislikes, dietary preferences, modified and special diets are accommodated. There is special equipment available for residents if required.</p> <p>The temperatures of refrigerators, freezers and cooked foods are monitored and recorded. All food is stored appropriately and dated. Residents and the family members interviewed were complimentary about the quality and variety of food served.</p> <p>Following the resident and family survey in 2014 the service identified that resident satisfaction around the food service could improve and a plan was developed and implemented to address this. Actions implemented included (but were not limited to): Purchase of a heated hot box is required to serve meals to the hospital dining room and for the room service (there are a lot of residents served in their rooms particularly at tea time). This also freed up the trays for any room service in the rest home dining room and ensured meals are served hot. A review of the breakfast and meal delivery process to rooms and the purchase of additional trolley's, which allow for staff to deliver to both ends of the facility at once. This has ensured meals are delivered in a timely manner and meals are kept warm. Thermos jugs for tea and coffee were purchased to ensure tea and coffee are delivered at the right temperature to residents. The kitchen staff hours were reviewed and the kitchenhands now start at 7am - 2pm and cooks 8.30am -5pm to ensure</p>

		the evening meal meets all resident requirements. Because of these improvements the resident satisfaction around the food service improved from 32% in 2014 to 52% being very satisfied in 2015 and 70% being very satisfied in the 2016 survey.
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	The service records the reasons for declining service entry to potential residents should this occur and communicates this decision to potential residents/family/whānau. Anyone declined entry is referred back to the referring agency for appropriate placement and advice.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	All appropriate personal needs information is gathered during admission, in consultation with the resident and their relative where appropriate. In files sampled appropriate assessment tools (paper-based for some residents and InterRAI for all aged care residents) were completed and assessments were reviewed at least six monthly or when there was a change to a resident's health condition in files sampled. Care plans are developed based on the outcomes of assessments.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	The long-term care plans reviewed described in detail, the support required to meet the resident's goals and needs and identified allied health involvement under a comprehensive range of template headings. Residents and their family/whānau are involved in the care planning and review process. Short-term care plans are in use for changes in health status. Staff interviewed reported they found the plans easy to follow.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Registered nurses (RNs), (including the clinical manager) and healthcare assistants follow the detailed and regularly updated care plans and report progress against the care plan each shift. When a resident's condition changes, the RN initiates a GP consultation or referral, for example to the gerontology nurse specialist. If external medical advice is required, this will be actioned by the GP. Staff have access to sufficient medical supplies (eg, dressings). Sufficient continence products are available and resident files include a continence assessment and plan. Specialist continence advice is available as needed and this could be described.

		<p>Comprehensive wound assessment, monitoring and wound management plans are in place for 13 residents with a total of 24 wounds (four residents have fragile skin and multiple wounds) which are being appropriately managed. The management of the wounds for two residents (both with more than one wound) is supported by the wound nurse specialist. There were no pressure injuries on the day of audit.</p> <p>Care plan interventions including intentional rounding also used for turning charts, food and fluid charts demonstrate interventions to meet resident's needs.</p> <p>Staff interviewed could describe appropriate behaviour management techniques that were individualised, particularly around younger residents.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>CI</p>	<p>A diversional therapist is employed fulltime and has been with the service for three years. She is supported by a regular volunteer. She has access to regional DT networks and support from the facility manager and from within the organisation. There are other volunteers involved in the activity programme including entertainers, church groups, RSA visits and one-on-one time with residents. The activities programme has been developed with significant input from the residents with the diversional therapist playing a coordinator role in supporting residents to self-determine group activities. Residents described that if a resident is observed to not be present at an activity they enjoy, another resident will notice and go to find the missing resident. Individual activities include resident's previous interests or occupations, such as repairing books, gardening or care of others. The service has exceeded the required standard around the activities programme provided. Activities and entertainment occur in the main lounge and the smaller lounges. Group activities reflect ordinary patterns of life such as baking, library books, board games, bowls, current affairs and arts and crafts. Outings into the community, to concerts and places of interest are planned. Special events are celebrated.</p> <p>All residents including younger residents are involved in a range of activities related to their specific interests. The diversional therapist could describe in detail the individual interests and the activities enjoyed by each of the younger resident's.</p> <p>All resident files sampled had a recent activities plan within the care plan and this was evaluated at least six monthly when the care plan is evaluated. Residents and families interviewed commented positively on the activity programme. Residents and families provide feedback on the activities through surveys, resident meetings and the six-monthly MDT reviews.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a</p>	<p>FA</p>	<p>The registered nurses evaluate all initial care plans within three weeks of admission. In files reviewed the long-term care plan was evaluated at least six monthly or earlier if there is a change in health status. The care plan evaluations reviewed that described progress to meeting resident goals. An RN signs care plan</p>

comprehensive and timely manner.		reviews. All changes in health status are documented and followed up. Short-term care plans are evaluated and resolved or added to the long-term care plan if the problem is ongoing as sighted in resident files reviewed. Where progress is different from expected, the service responds by initiating changes to the care plan.
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The nurses initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs. Referrals and options for care were discussed with the family as evidenced in interviews and medical notes. The staff provided examples of where a resident's condition had changed and the resident reassessed. Examples of close liaison with dietitians, physiotherapist, mental health staff and social workers were sighted in resident files reviewed.
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	There are implemented policies in place to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles are available and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals sighted were labelled correctly and were stored safely throughout the facility. Safety datasheets are available. The two sluice rooms (one each wing) have personal protective clothing readily available.
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	The building has a current building warrant of fitness that expires 16 April 2017. The building has a number of alcoves and lounge areas. There is a full-time maintenance person employed to address the reactive and planned maintenance programme. All medical and electrical equipment was recently serviced and/or calibrated. Essential contractors are available 24 hours. Hot water temperatures are monitored monthly and are maintained between 43-45 degrees Celsius. The facility has sufficient space for residents to mobilise using mobility aids. Residents have access to external areas that have seating and shade. The service has exceeded the required standard around the provision of outdoor areas that residents enjoy. There is an outdoor designated resident smoking area. Staff stated they had sufficient equipment to safely deliver the

		<p>cares as outlined in the resident care plans.</p> <p>In early 2015 a project was commenced to improve the equipment and facility to better meet residents' desires and expectations. All beds (except where the resident declined) were replaced and a lounge frequently used by small groups and families had a complete makeover with new furniture, TV, DVD and new bookcase for library books. An extra three hours has been allocated to cleaning on a Saturday to ensure common areas and bathrooms are maintained to a higher standard. Each room has been redecorated with paint, new carpet if required, new curtains, a replacement vanity and a replacement wardrobe if required. Following these and other interventions targeted at the needs of specific residents, satisfaction with the facility improved from 44% in the 2014 survey to 70% in the 2015 survey and 85% in the 2016 survey. Residents took pride in showing the facility and their areas to the audit team during the audit.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are an adequate number of communal toilets and shower/bathing areas for residents. One room has an ensuite. Toilets and showers have privacy systems in place. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>All resident's rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids, including those required by hospital level and residential disability care residents. Residents are encouraged to personalise their bedrooms. Electric beds and ultra-low beds are used for hospital residents and residential disability residents as assessed.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment,</p>	FA	<p>There is a large communal lounge, a smaller lounge in the hospital area and several smaller lounges, at the end of each wing. There is a main dining room adjacent to the kitchen and a dining room for the hospital</p>

<p>Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>		<p>wing. There is safe and easy access to communal areas.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>All laundry including personal clothing is laundered on site by dedicated laundry staff. There is a laundry area with defined dirty/clean areas. The two laundry/cleaning staff interviewed report that support and equipment is suitable for the tasks they undertake. They have access to a range of chemicals, cleaning equipment and protective clothing. The standard of cleanliness is monitored through the internal audit programme. Residents and relatives interviewed were satisfied with the standard of cleanliness in the facility. The cleaners' trolley was well equipped and stored in designated locked rooms when not in use.</p> <p>Residents and relatives interviewed were satisfied with the laundry service.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>There are emergency and disaster manuals to guide staff in managing emergencies and disasters. There is a minimum of one first aid trained staff member on every shift and during outings. The facility has an approved fire evacuation plan. Fire drills take place every six months. Supplies of stored water and food are held on site and are adequate for three days. There is a gas barbeque and spare gas bottles. Civil defence bins/supplies are checked six monthly. Electronic call bells were evident in resident's rooms, lounge areas, and toilets/bathrooms.</p> <p>The facility is locked from dusk and staff answer the door to allow visitors access after this when required.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>General living areas and all resident rooms are appropriately heated with radiator heating that is adjustable in the resident's rooms. The facility is well ventilated when required. All rooms have external windows that open allowing plenty of natural sunlight.</p>

<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>Radius Peppertree has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system and the Radius KPIs. A registered nurse is the designated infection control nurse with support from the facility manager, clinical manager and the quality management committee (infection control team). Minutes are available for staff. Audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The Radius infection control programme was last reviewed in July 2016.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>A registered nurse at Radius Peppertree is the designated infection control (IC) nurse. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurse and IC team (comprising the quality management team and care staff) has good external support from the local laboratory infection control team and IC nurse specialist at the DHB. The infection control team is representative of the facility. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the</p>	<p>FA</p>	<p>There are Radius infection control policies and procedures appropriate to for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies were developed by the Radius clinical management team and have been reviewed and updated.</p>

type of service provided.		
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred. The infection control nurse has completed infection control training. 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 medical records.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Infection surveillance is an integral part of the infection control programme and is described in Radius' infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed which includes signs and symptoms of infection, treatment, follow-up, review and resolution. Short-term care plans are used. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually, and is provided to Radius head office. Infections are part of the key performance indicators. Outcomes and actions are discussed at quality meetings and staff meetings and plans and interventions resulting from surveillance create improvements in a way that exceeds the required standard. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the acting facility manager. An outbreak in March 2015 was appropriately managed.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. Restraint minimisation policies and procedures are comprehensive, and include definitions, processes and use of restraints and enablers.</p> <p>There were three residents using enablers and three hospital residents with restraints during the audit. All enablers and restraints used were bedrails.</p> <p>Two resident files were reviewed where an enabler was in use. Voluntary consent and an assessment process were completed. The enablers were linked to the residents' care plans and regularly reviewed.</p> <p>Staff training is in place around restraint minimisation and enablers, falls prevention and analysis and management of challenging behaviours.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process</p>	FA	<p>The restraint approval process is described in the restraint minimisation policy. Roles and responsibilities for the restraint coordinator (clinical manager) and for staff are documented and understood. The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and</p>

for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.		monitoring requirements.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	<p>A restraint assessment tool is completed for residents requiring an approved restraint for safety. The restraint coordinator in partnership with the RNs, GP, resident and their family/whānau, undertakes assessments. Restraint assessments are based on information in the care plan, resident/family discussions and observations.</p> <p>Ongoing consultation with the resident and family/whānau are evident. Two hospital-level residents where restraint was in use (bed rails), were selected for review. The completed assessment considered those listed in 2.2.2.1 (a) - (h).</p>
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	<p>Procedures around monitoring and observation of restraint use are documented in policy. Approved restraints are documented. The restraint coordinator is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialed before implementing restraint.</p> <p>Restraint authorisation is in consultation/partnership with the resident and family and the GP. The use of restraint is linked to the residents' care plans. Internal restraint audits measure staff compliance in following restraint procedures. Each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. Monitoring is documented on a specific restraint monitoring form, evidenced in two resident files where restraint was being used.</p> <p>A restraint register is in place providing an auditable record of restraint use and is completed for all residents requiring restraints and enablers.</p>
Standard 2.2.4: Evaluation Services evaluate all	FA	The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations are conducted monthly as part of the restraint committee meeting. A review of two resident files identified that evaluations were up-

episodes of restraint.		to-date.
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>The restraint minimisation programme is discussed and reviewed at the monthly facility meetings, attended by the restraint coordinator (clinical manager), RNs and HCAs. Meeting minutes include (but are not limited to) a review of the residents using restraints or enablers, updates (if any) to the restraint programme, and staff education and training.</p>

Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

No data to display

Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.1.13.1</p> <p>The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.</p>	CI	<p>A range of data relating to complaints, incidents, accidents, health and safety, risk management and internal audit reports is used to improve the service. Projects are undertaken where opportunities for improvements are identified. A quality initiative was implemented in August 2015 that all concerns are to be addressed immediately and communication to ensure residents and families are satisfied with outcomes. Monthly meetings are held at regular intervals to communicate quality initiatives and outcomes. A reduction in complaints over the last 2 years has been a focus for Radius Peppertree and in building trusting relationships with residents and</p>	<p>A reduction in complaints over the last 2 years has been a focus for Radius Peppertree and in building trusting relationships with residents and families. Previous mistrust and failure to communicate effectively with families was the most common issue raised by complainants. Complaints are reviewed monthly at quality, health and safety meeting and discussed at RN and staff meetings. Staff at Peppertree have all been educated on open disclosure to ensure that they openly work with residents and families to correct/improve any issues raised and thorough documentation of all complaints and concerns.</p> <p>Resident satisfaction survey results clearly indicate a sustained and increasing level of satisfaction. The reduction in complaints over the last three years indicates that the service provision, communication and satisfaction has increased considerably. There were 27 complaints received in 2014, four complaints received in 2015 and no complaints made in 2016 (four concerns, all documented). Compliments from residents and family have increased over the last three years from 21 received in 2014, 30 received in 2015 and 33 received in 2016.</p>

		families.	
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	CI	<p>There is an implemented annual education and training plan that exceeds eight hours annually. All staff participate in continuing education relevant to physical disability and young people with physical disabilities. There is an attendance register for each training session and an individual staff member record of training. Staff are required to complete written core competencies during their induction. These competencies are repeated annually.</p>	<p>Radius Peppertree reviewed the education programme in August 2015 as education attendance for compulsory education was low. Attendance at in-service education sessions in 2014 was recorded between 18 to 30%. Feedback from staff was that they found it to be difficult coming in for 1 hour sessions. A review of how education sessions took place to ensure maximum attendance of staff. Due to the staff feedback, sessions were changed from 1 hour monthly sessions to 4-5 hour sessions every three months. A roster was developed with each education session to ensure staff were released from work to attend. Sessions were also conducted over two days to ensure we captured all staff.</p> <p>Staff have engaged in additional education over the last twelve months with 15 completing 'reach up with Radius', diversional therapist training, walking in another's shoes and Ace training. Staff have expressed at performance appraisal, requests for further education in dementia, palliative care and attendance at the next 'reach up with Radius' programme. Analysis of staff education shows a large increase in attendance and consistent satisfaction with education feedback. Attendance at in-service education sessions in 2016 was recorded between 72% - 93%. As a result of better educated staff, service provision has improved. This has resulted in a significant increase in resident and family satisfaction in every domain covered in the survey, between the 2014 and 2016 surveys.</p>
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	CI	<p>The activities programme is reported as constantly being reviewed to ensure it encompasses the needs of different groups of residents with varying abilities and interests.</p>	<p>In 2014 the service identified that the activities programme was not meeting the individual needs of residents. A corrective action plan was developed to address this, which included residents being given an opportunity to provide ideas for the programme at each residents meeting and any other time. New ideas suggested by residents and tried, included cooking, more exercise and games, walking groups and crafts. Newspaper reading commenced to keep residents interested and knowledgeable of what is happening both locally and internationally. A DVD player was installed in the hospital wing so that residents can have movies days and more games and colouring equipment was also purchased for the hospital wing. Extra activities staff hours were provided specifically for the hospital wing and</p>

			<p>new resource books were purchased. The diversional therapist completed dementia qualifications. Because of these interventions, satisfaction survey results for activities questions improved from a 22% satisfaction rate in 2014 to 78% in 2016. Residents interviewed felt that their time was occupied in meaningful ways that were stimulating and provided worth and value to their days.</p>
<p>Criterion 1.4.2.6 Consumers are provided with safe and accessible external areas that meet their needs.</p>	<p>CI</p>	<p>The outdoor environment at radius Peppertree was pleasant and well-kept but fairly plain and the facility, with resident and family input, determined to make the environment a place residents are proud of and can enjoy.</p>	<p>In 2014 a project was undertaken to provide an outdoor environment that was more user friendly and enjoyable for residents. A new gardener was hired and a garden club was started with residents. The activities coordinator took residents to garden centres to choose what flowers they wanted for hanging baskets and then the residents planted them. New outdoor furniture and umbrellas were purchased and two park benches were donated by family members, one with a memorial plaque on it. The manager and gardener continue to consult residents around choices for planting and improvements. The garden club continues to be popular.</p> <p>In December 2015, the service started a Save the Bees campaign which included research and the purchase of beehives. This has directly impacted on what planting happens at the facility. This has received a newspaper article and residents interviewed were proud of their interest and knowledge in this area. There are ongoing improvements suggested by residents for improvements to the grounds. Resident satisfaction with outdoor areas has improved from 66% to 78%.</p>

End of the report.