Harbour Quays Residential Aged Care

Performance Report

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**Commission ID:** 5793

**Provider name:** Provectus Care Pty Limited

**Site Audit date:** 6 December 2021 to 8 December 2021

**Date of Performance Report:** 4 February 2022

# Performance report prepared by

Alice Redden, delegate of the Aged Care Quality and Safety Commissioner.

# Publication of report

This Performance Report **will be published** on the Aged Care Quality and Safety Commission’s website under the Aged Care Quality and Safety Commission Rules 2018.

# Overall assessment of this Service

|  |  |
| --- | --- |
| **Standard 1 Consumer dignity and choice** | **Compliant** |
| Requirement 1(3)(a) | Compliant |
| Requirement 1(3)(b) | Compliant |
| Requirement 1(3)(c) | Compliant |
| Requirement 1(3)(d) | Compliant |
| Requirement 1(3)(e) | Compliant |
| Requirement 1(3)(f) | Compliant |
| **Standard 2 Ongoing assessment and planning with consumers** | **Non-compliant** |
| Requirement 2(3)(a) | Compliant |
| Requirement 2(3)(b) | Non-compliant |
| Requirement 2(3)(c) | Compliant |
| Requirement 2(3)(d) | Non-compliant |
| Requirement 2(3)(e) | Compliant |
| **Standard 3 Personal care and clinical care** | **Compliant** |
| Requirement 3(3)(a) | Compliant |
| Requirement 3(3)(b) | Compliant |
| Requirement 3(3)(c) | Compliant |
| Requirement 3(3)(d) | Compliant |
| Requirement 3(3)(e) | Compliant |
| Requirement 3(3)(f) | Compliant |
| Requirement 3(3)(g) | Compliant |
| **Standard 4 Services and supports for daily living** | **Compliant** |
| Requirement 4(3)(a) | Compliant |
| Requirement 4(3)(b) | Compliant |
| Requirement 4(3)(c) | Compliant |
| Requirement 4(3)(d) | Compliant |
| Requirement 4(3)(e) | Compliant |
| Requirement 4(3)(f) | Compliant |
| Requirement 4(3)(g) | Compliant |
| **Standard 5 Organisation’s service environment** | **Compliant** |
| Requirement 5(3)(a) | Compliant |
| Requirement 5(3)(b) | Compliant |
| Requirement 5(3)(c) | Compliant |
| **Standard 6 Feedback and complaints** | **Compliant** |
| Requirement 6(3)(a) | Compliant |
| Requirement 6(3)(b) | Compliant |
| Requirement 6(3)(c) | Compliant |
| Requirement 6(3)(d) | Compliant |
| **Standard 7 Human resources** | **Non-compliant** |
| Requirement 7(3)(a) | Non-compliant |
| Requirement 7(3)(b) | Compliant |
| Requirement 7(3)(c) | Compliant |
| Requirement 7(3)(d) | Compliant |
| Requirement 7(3)(e) | Compliant |
| **Standard 8 Organisational governance** | **Compliant** |
| Requirement 8(3)(a) | Compliant |
| Requirement 8(3)(b) | Compliant |
| Requirement 8(3)(c) | Compliant |
| Requirement 8(3)(d) | Compliant |
| Requirement 8(3)(e) | Compliant |

# Detailed assessment

This performance report details the Commissioner’s assessment of the provider’s performance, in relation to the service, against the Aged Care Quality Standards (Quality Standards). The Quality Standard and requirements are assessed as either compliant or non-compliant at the Standard and requirement level where applicable.

The report also specifies areas in which improvements must be made to ensure the Quality Standards are complied with.

The following information has been taken into account in developing this performance report:

* the Assessment Team’s report for the Site Audit; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others.
* the provider’s response to the Site Audit report received 14 January 2022.

# STANDARD 1 COMPLIANT Consumer dignity and choice

### Consumer outcome:

1. I am treated with dignity and respect, and can maintain my identity. I can make informed choices about my care and services, and live the life I choose.

### Organisation statement:

1. The organisation:
2. has a culture of inclusion and respect for consumers; and
3. supports consumers to exercise choice and independence; and
4. respects consumers’ privacy.

## Assessment of Standard 1

The Quality Standard is assessed as Compliant as six of the six specific requirements have been assessed as Compliant.

Consumers interviewed consider they are almost always treated with dignity, kindness and respect by staff, though some representatives felt that agency staff are sometimes not as respectful. Consumers considered, and service documents demonstrated, that services provided are tailored to reflect the service’s diversity and are culturally safe. Consumers reported they receive support to express and maintain their individual religious identities.

Consumers mostly considered they can make informed choices about their care, services, the activities they participate in and how they spend their time. Consumers confirmed staff know and respect their preferences, including the relationships they choose to maintain, their religious activities, and the people they want involved in their care and decision making.

Consumers and their representatives stated the service provides appropriate and timely information to support consumer’s choices, and privacy is respected by maintaining confidential information, using password-protected systems, conducting staff handovers in private and respecting consumers’ personal space and their belongings.

The service demonstrated it has effective processes to identify and communicate consumers’ unique cultural, spiritual and social needs, goals and preferences. Care planning documentation showed practice is in accordance with the service’s diversity and action plan, inclusion policy and underpinning policies and procedures.

The service supports consumers to continue living the life they choose and where risks are involved, the service has effective mitigation strategies in place. Consumers and their representatives are involved in risk assessments which are conducted by the relevant professionals. Dignity of Risk forms are completed where consumers or representatives choose to accept the assessed risk.

The service provides accurate and up to date information to consumers and ensures consumers’ choices are recorded and communicated to those providing care and services. There are processes to provide consumers and representatives with information about what is happening in the service, and this information is delivered in a variety of ways to accommodate those with different sensory needs or communication difficulties.

## Assessment of Standard 1 Requirements

### Requirement 1(3)(a) Compliant

*Each consumer is treated with dignity and respect, with their identity, culture and diversity valued.*

### Requirement 1(3)(b) Compliant

*Care and services are culturally safe.*

### Requirement 1(3)(c) Compliant

*Each consumer is supported to exercise choice and independence, including to:*

1. *make decisions about their own care and the way care and services are delivered; and*
2. *make decisions about when family, friends, carers or others should be involved in their care; and*
3. *communicate their decisions; and*
4. *make connections with others and maintain relationships of choice, including intimate relationships.*

### Requirement 1(3)(d) Compliant

*Each consumer is supported to take risks to enable them to live the best life they can.*

### Requirement 1(3)(e) Compliant

*Information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice.*

### Requirement 1(3)(f) Compliant

*Each consumer’s privacy is respected and personal information is kept confidential.*

# STANDARD 2 NON-COMPLIANT Ongoing assessment and planning with consumers

### Consumer outcome:

### I am a partner in ongoing assessment and planning that helps me get the care and services I need for my health and well-being.

### Organisation statement:

1. The organisation undertakes initial and ongoing assessment and planning for care and services in partnership with the consumer. Assessment and planning has a focus on optimising health and well-being in accordance with the consumer’s needs, goals and preferences.

## Assessment of Standard 2

The Quality Standard is assessed as Non-compliant as two of five specific requirements have been assessed as Non-compliant.

The Assessment Team found the service did not meet Requirements (3)(b) and (3)(d) in this Standard. Based on the evidence supplied by the Assessment Team and the Approved Provider’s response, I agree with the Assessment Team’s non-compliant recommendations against both Requirements. I have provided reasons for my finding in the respective Requirements below.

The Approved Provider demonstrated effective assessment and planning which considers specific risks to consumers’ safety, health and wellbeing. Consumers, representatives and relevant professionals are kept informed and collaborate where necessary in the planning and assessment process. Comprehensive assessments occur on entry to the service, specific risks for each consumer are documented, mitigation strategies are included in care plans and care plans reviewed as required. Staff gave clear accounts of their roles and accountabilities in assessment and planning processes. Policies and procedures support the service to deliver safe and effective care and services

Consumers, representatives and staff confirmed the people consumers want to have involved in assessment and planning are included and the service refers consumers to external professionals. However, whilst consumers and representatives reported being involved in assessment and care planning, consumer care information was not always consistently documented or retrievable at the point of service delivery.

## Assessment of Standard 2 Requirements

### Requirement 2(3)(a) Compliant

*Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services.*

### Requirement 2(3)(b) Non-compliant

*Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes.*

The Assessment Team found that while consumer care and service plans were individually tailored and documented for each sampled consumer, Advanced Care Plans (ACP) and End of Life (EOL) plans did not consistently capture current needs, goals and preferences. As a result, the Assessment Team recommended ‘Non-compliant,’ based on the following relevant (summarised) evidence:

* Three out of four sampled representatives stated that although EOL plans and ACPs were discussed upon entry to the service, they were not subsequently updated, including in an instance when a representative had asked to do so.
* Staff feedback confirmed that EOL and ACP documentation required updating with consumers and their representatives.
* Review of care planning documentation corroborated confirmed staff responses that ACP and EOL information was not updated in line with consumer requests or change in circumstances.
* Consumer/ representative feedback also raised concerns regarding updating EOL plans:
  + Consumer A’s representative advised she had asked to update the consumer’s EOL plan as their health is declining, but the care manager she had asked ‘did not follow up.’
  + Consumer B’s representative stated they had completed an EOL planning form on arrival to the service, but this had not been updated since.

Based on the evidence (summarised above), the Assessment Team recommended not met against this requirement.

In their response to the Assessment Team’s recommendation, the provider put forth the following relevant (summarised) arguments:

* Upon entry to the service, all consumers are asked if they have an AHD or an EOL plan in place and if not, whether they want to put some in place. The service provides information and the relevant forms (depending on consumer choice) at that point.
* Consumers are informed via the Resident Handbook and newsletters how they can update their EOL plans or put in place or update an ACP.
* The service conducts annual reviews of consumer care plans where EOL matters are discussed. Consumers and their representatives are asked if they want to update the choices they made on admission to the service. If they do not wish to update them, the information recorded in their care plans will remain as captured on their entry to the service.
* The service considers it inappropriate to continuously ask consumers and representatives if they want to revise their earlier choice.
* Consumer A has an appointed guardian for decision making and a family conference was held in April 2021, where information about ACP and an EOL planning form was provided. The form has not been returned to the service. The service provided evidence of the discussion of ACP and EOL planning in April 2021, however, the service did not provide evidence of follow up with the family in relation to the paperwork between April 2021 and November 2021, when the consumer received a significant diagnosis. Since then, the service has provided opportunities for EOL planning however the family have been unable to make any plans in this time. The service continues to follow up.
* Consumer B has opted not to complete an AHD or Statement of Choices on admission, preferring to rely on their appointed Enduring Power of Attorney (EPOA). The service advised they had attempted, unsuccessfully, to schedule care plan reviews, including EOL planning in December 2020 and February 2021. In February 2021, care planning documents were sent via email to the EPOA with a request they advise by email if any updates were to be made. The Approved Provider’s response did not evidence any further follow-up with the EPOA and family between February 2021 and early December 2021. An EOL plan was completed after the time of Site Audit.

I acknowledge the Approved Provider’s response to the Site Audit Report and their policies and procedures relating to EOL care, assessment and planning. However, I find that at the time of Site Audit, the service did not have current ACP or EOL planning documentation for Consumers A and B and there was significant length of time where the service did not evidence any follow up with the representatives of those consumers.

Lastly, I acknowledge the service has accessible information about updating EOL plans and ACPs available to consumer. However, I do not believe this overcomes lack of follow up with the representatives of Consumers A and B during 2021. The lack of follow up was not noted or acknowledged by the Approved Provider in their response, suggesting that an opportunity for improvement has not been identified.

As a result, I find that at the time of Site Audit, the service could not demonstrate their assessment and planning always identified and addressed the consumer’s current needs, goals and preferences of consumers in relation to EOL planning.

For the reasons detailed above, I find Harbour Quays Residential Aged Care to be non-compliant with Standard 2 Requirement (3)(b).

### Requirement 2(3)(c) Compliant

*The organisation demonstrates that assessment and planning:*

1. *is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer’s care and services; and*
2. *includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer.*

### Requirement 2(3)(d) Non-compliant

*The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided.*

The Assessment Team found the service demonstrated effective communication of assessment and planning outcomes to consumers and representatives, however did not evidence they consistently document consumer care information. As a result, they found the outcomes of assessment and planning were not always readily available to consumers. Summarised relevant evidence included:

* All sampled consumers and representatives were aware of the existence of care plans and were comfortable to request access if needed, however, at the time of audit, the service was changing over to a new Electronic Care Management System (ECMS) and consumer care information had been mismanaged during the changeover. As a result, Behaviour Support Plans for two consumers subject to chemical restraints were either not completed or not uploaded to the ECMS,
* Two staff members stated the changeover from paper-based files to the ECMS had made finding consumer information difficult and care staff feedback indicated that progress notes were not always updated soon after care is provided.
* Staff were observed having difficulty finding Behaviour Support Plans (BSP) due to the shift to an ECMS and some information was not able to be accessed as all.

Based on the evidence (summarised above), the Assessment Team found that current, accurate and comprehensive care planning documentation was not readily available for consumers or their representatives. In their response to the Assessment Team’s report, the provider led the following relevant (summarised) arguments:

* The Service’s transition from a paper-based system to an ECMS was unrushed and well-considered. The service developed a gradual implementation plan, after it was determined it was not possible to switch entirely from paper-based to the ECMS on one date.
* The service’s transition plan lasted from July 2021 to January 2022, supporting staff to become familiar with the ECMS gradually. Staff received training and approval to continue using certain paper-based processes and documents when a management or clinical decision had been made to do so.
* The decision to transition gradually to the ECMS was made because aspects of the ECMS system were found to be non- compliant with recent legislative changes and the existing paper-based forms and tools were preferable. Specifically, the service considered the ECMS was not yet fully compliant with the new requirements for BSPs. As a result, a paper-based system continued to be used, with fully completed BSPs being scanned and uploaded to the ECMS. Where BSPs were still in development, the service could rely on the paper-based version. The Approved Provider stated their confidence that staff had “ready access to BSPs either electronically or in hard copy.”
* Because the Site Audit Report did not identify the two BSPs which were either not completed or not uploaded to the ECMS, the provider asserted they were not able to evidence these were completed or held in paper format.
* The Approved Provider argued that staff were adequately supported with the transition to the ECMS and enough devices were provided to ensure staff access, however some staff are more capable than others at embracing change and learning new technologies.
* The Approved Provider questioned a staff member about the content of their discussion with the Assessment Team and issued a retraction on that staff member’s behalf.
* Most staff were satisfied with the introduction of the ECMS and they consider it has significantly improved the documentation and availability of information to staff, consumers and representatives.

Based on the evidence in the Site Audit Report and the Approved Provider’s response, I find that the outcomes of assessment and planning where not readily available where care and services were provided. The reasons for my decision are as follows:

* Although the Assessment Team did find the results of assessment and planning were effectively communicated to consumers and their representatives, that is only part of Requirement 2(3)(d). The Assessment Team’s observations and the staff feedback provided during the site audit clearly demonstrated that consumer information and documentation was not readily available at the point where care and services were provided.
* The Assessment Team directly observed staff struggling to locate BSPs, which suggests the transition plan was not always effective. The transition period from July 2021- January 2022 was near its end at the time of Site Audit, suggesting issues with the system should have been identified and resolved by then. The provider also did not supply any evidence of the transition plan they referred to.
* I note the Approved Provider’s assertion that they were not able to evidence whether the two BSPs that staff could not locate were in fact held in hard or electronic copy. It is irrelevant whether the BSPs were held or not in either format. If the transition plan had been effective, staff on the day of the Site Audit should have been able to find them electronically. Alternatively, if they were not yet uploaded, staff should have been able to refer to the paper version in development.
* The Approved Provider asserted that staff were adequately supported in their transition to the new ECMS however provided no evidence of relevant staff training.
* The Approved Provider issued a clarification of the feedback a staff member gave directly to the Assessment Team. I have disregarded the clarification, as the feedback provided during the Site Audit tends to be consistent with the Assessment Team’s observations on the day. I note the Approved Provider referred to the ‘vast majority’ of staff being satisfied with the new ECMS, however no evidence of this was provided and so it does not displace direct verbal feedback and observations of staff struggling to locate consumer documentation at the point of service delivery.

As a result, I find that at the time of Site Audit, the service could not demonstrate the results of assessment and planning were always readily available at the point where care and services are delivered.

For the reasons detailed above, I find Harbour Quays Residential Aged Care to be non-compliant with Standard 2 Requirement (3)(d).

### Requirement 2(3)(e) Compliant

*Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer.*

# STANDARD 3 COMPLIANT Personal care and clinical care

### Consumer outcome:

1. I get personal care, clinical care, or both personal care and clinical care, that is safe and right for me.

### Organisation statement:

1. The organisation delivers safe and effective personal care, clinical care, or both personal care and clinical care, in accordance with the consumer’s needs, goals and preferences to optimise health and well-being.

## Assessment of Standard 3

The Quality Standard is assessed as Compliant as seven of the seven specific requirements have been assessed as Compliant.

The Assessment Team recommended Requirements (3)(a), 3(b), 3(c) and 3(d) in this Standard as Non-compliant.

Based on the evidence in the Site Audit report and the Approved Provider’s response, I disagree with the Assessment Team’s recommendations and find the service to be compliant with Requirements (3)(a), 3(b), 3(c) and 3(d). I have provided reasons for my decision in the relevant Requirements below.

The Assessment Team found that information about consumer needs, preferences and care requirements were mostly communicated effectively within the organisation and to those external professionals and representatives involved in consumer care. Consumer and representative feedback, as well as document review, indicated that information is mostly, shared via care plans, progress notes and via shift handovers. Staff interviewed were able to describe handover and escalation processes and how family and representatives were kept informed of changes in consumer condition, clinical incidents and changes in medication. Care planning documentation, consumer and representative feedback and staff interviewed confirmed that consumers are referred to external professionals when needed.

Assessment Team observations, staff interviews, review of policy and procedure documents and consumer/ representative feedback indicated that the service uses standard and transmission-based precautions to minimise infections in the service. The service has established practices in place to promote the responsible use of antibiotics and reduce risk of increased antibiotic resistance. Interviewed staff were familiar with antimicrobial stewardship practices and confirmed they are provided training on this. Staff were knowledgeable about COVID-19 precautions taken in the service, however it is noted that one representative voiced concern that there had been a lack of communication about visiting during a recent lockdown period.

### Assessment of Standard 3 Requirements

### Requirement 3(3)(a) Compliant

*Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:*

1. *is best practice; and*
2. *is tailored to their needs; and*
3. *optimises their health and well-being.*

The Assessment Team found the service did not comply with this requirement as understaffing had led to poor consumer outcomes and use of restrictive practices in the services were not in line with best practice or legal requirements. Relevant summarised evidence included:

* Consumer D, a consumer new to the service, was admitted directly from hospital with documentation showing allergies to oxycodone and morphine. The consumer’s care plan however, listed only an allergy to oxycodone and the consumer’s progress notes indicated they had been administered the drug 15 times since entering the service. The consumer was later confirmed to be allergic only to morphine.
* Consumer E was accidentally administered their three monthly B12 injection twice in a month.
* Consumers with challenging behaviours were subject to restrictive practices that were not being used as a last resort, some consumer documents did not contain consent for restrictive practices already being used and BSPs were sometimes non-existent or not readily available. The service was not compliant with recent changes in legislation requiring BSPs for all consumers subject to restraints.
* While most consumers and representatives interviewed were satisfied with the way skin and pain are managed at the service, three of four representatives interviewed raised concerns about the quality and timeliness of care. For example:
  + The representative of Consumer A reported the consumer’s GP had discovered a progressing pressure wound that had not been identified by staff. On another occasion, when the consumer was hospitalised, staff did not inform the hospital of the course of antibiotics he was on, resulting in the consumer failing to finish the course. The same representative reported they had requested an air mattress, which had not been provided and advised they visit each morning to ensure the consumer is receiving care.
  + Other representatives reported that there are insufficient staff to care for consumers, which on one occasion led to Consumer C attempting to self-mobilise and falling, while the representative of Consumer F reported agency staff do not know how to use hoisting equipment and that he had purchased a standing aid for his family member.
* Interviewed care staff reported often being too busy to fulfil consumers’ daily-living requests and respond to consumer needs including continence care and call bell requests, as well as difficulty accessing consumer information with the transition to the new ECMS, as discussed at Requirement 2(3)(d).
* Care staff reported that being short-staffed and having multiple roles as prevented them from providing tailored care to consumers.
* Some restrictive practices had been implemented without their use being authorised by the consumer or their representative. Alternatives to restraints were not documented in care plans.

Based on the evidence (summarised above), the Assessment Team recommended that the service was Non-compliant with this Requirement. In their response, the Approved Provider disagreed with the Assessment Team’s findings and put forth the following arguments:

* The service demonstrated that Consumer D who had been given oxycodone was not placed at any actual risk and demonstrated the original error had been made in the Hospital Discharge Summary. While the error in the information was not identified and corrected at the point of input into the provider’s system, the prescribing and medication taken by the consumer was established and verified by the provider through consultation with the consumer’s GP. I accept the provider’s account of how the error occurred and that they instituted an appropriate response to the incident.
* In relation to Consumer E, the provider demonstrated the incident was already identified by the service prior to the Site Audit and was managed in accordance with their Incident Management System. The provider supplied additional context and reported the root cause of the incident was an error made by an external medical practitioner. The provider advised they implemented improvements to their handover system as a result of the incident and clarified that Consumer E was not hospitalised as a result of the addition B12 injections.
* The provider disagreed with findings relating to BSPs and referred to their previous response under Requirement 2 (3)(d), arguing staff had ready access to all BSPs held in both paper and electronic format. They also argued there were no consumers identified in the report who were subject to restrictive practices not used as a last resort and the Site Audit Report did not give any specific, named examples to evidence their finding that some restrictive practices were used without documented consent.
* The provider disagreed with the consumer representative feedback. They provided evidence of the time line of clinical monitoring and skin assessment for Consumer A, which demonstrated that the service had provided appropriate skin care and wound management to the Consumer. They demonstrated that during Consumer A’s hospitalisation, information about his medication was handed over and they showed that his pressure injury risk and pain were being managed appropriately at the time of Site Audit.
* The response accounted for the service’s management of Consumer C’s falls risk, describing a comprehensive range of falls prevention measures in place.
* The provider responded to concerns raised about Consumer F with evidence of the orientation process for agency staff, which includes training on manual handling equipment and processes. The provider also reported they have sufficient lifting, transfer and mobility equipment on each floor but that some consumers have purchased their own lifting equipment.
* They outlined the policies, procedures and systems in place to direct staff in skin care, pressure injuries and monitoring, mobility and falls prevention. The provider also detailed the service’s Clinical Governance Framework and supporting policies and procedures to minimise the use of restrictive practices.

Having regard to the Assessment Team’s findings, and the arguments and evidence put forth by the Approved Provider in their response, I find the service is Compliant with this Requirement because of a lack of evidence to support the ‘not-met’ recommendation. Only two examples of sampled consumer care planning documents indicating that care received does not accord with this Requirement were provided and the deficiencies identified in relation to those consumers were addressed by the Approved Provider in their response. The Approved Provider’s response to representative feedback for Consumers A, C and F was reasonable and tended to demonstrate that care had been provided in line with evidence-based practice. There was no evidence of systemic issues with the recording of allergy information or the management of medication at the service and no specific evidence of consumers with unauthorised restrictive practices, or consumers whose restrictive practices were used other than as a last resort.

I note the Approved Provider did not address negative staff feedback against this standard and I acknowledge my previous finding that the transition to the new ECMS appears to have made BSPs less accessible at the point of service delivery. However, on balance, I find that these points are not sufficient to support a ‘not met’ recommendation. Staff feedback did not specify specific negative consumer outcomes relating to personal and/or clinical care and issues related to the ECMS transition and to staffing are comprehensively assessed in other Requirements.

For the reasons detailed above, I disagree with the Assessment Team’s findings and instead, find Harbour Quays Residential Aged Care to be compliant with Standard 3 Requirement (3)(a).

### Requirement 3(3)(b) Compliant

*Effective management of high impact or high prevalence risks associated with the care of each consumer.*

The Assessment Team found the service mostly demonstrated effective management of high-impact or high prevalence risks such pain, falls, swallowing and behaviour support.

Consumer care planning documentation demonstrated the service appropriately identifies issues with mobility, skin integrity and behaviour management. The Assessment Team found the service consistently implements strategies to manage risks and monitors their effectiveness. Staff interviews against this standard indicated that high impact and high prevalence risks associated with consumer care were effectively managed. However, the Assessment Team recommended the service was not compliant with this Requirement, based on the following relevant evidence:

* The Assessment Team found the service had repeatedly administered oxycodone to a consumer who was listed as allergic to the drug (refer to Standard 3, Requirement (3)(a) for further detail.
* While two representative’s feedback indicated the service effectively manages high impact and high prevalence risks experienced by consumers, another representative was concerned that excessive call bell wait times would result in another fall for Consumer C, while the representative for Consumer A advised their request for an air mattress had been ignored.

Based on the evidence (summarised above), the Assessment Team recommended the service was Non-compliant with this Requirement.

In their response to the Site Audit Report, the Approved Provider:

* Referred to their previous arguments against Requirement 3 (3)(a) relating to Consumer D who had the incorrect allergy information listed.
* In relation to Consumer C, the Approved Provider referred to their previous arguments in Requirement 3 (3)(a). They disagreed with the Assessment Team’s findings and provided evidence of their mobility and falls prevention policies and procedures and the falls prevention measures used to manage Consumer C’s high falls risk.
* In relation to Consumer A, the Approved Provider’s response suggests that they initially formed the view consumer A did not require an air mattress and that his existing mattress was preferable. The Approved Provider advised that Consumer A was eventually provided with an air mattress due to an increased risk of pressure injuries identified after the Site Audit. The provider argued that even if it is accepted that an air mattress was more appropriate than the existing mattress and should have been provided immediately, they argue Consumer A’s pain and pressure injury were being otherwise, comprehensively managed.
* The response quoted the Assessment Team’s findings that the service has good strategies for management of high impact and high prevalence risks and pain management and they provided additional information regarding the documented policies and procedures which guide risk management practice at the service. The Approved Provider referred to Weekly Clinical Risk Meetings which brings together senior clinicians, other medical practitioners and allied health team members to collaboratively identify and assess needs of high-risk consumers and make referrals as necessary.

Having regard to the Assessment Team’s findings, and the arguments and evidence put forth by the Approved Provider, I disagree with the Assessment Team’s ‘not met’ recommendation, for the following reasons:

* The Assessment Team found that eight out of nine sampled care planning documents indicated high prevalence and high impact risks were effectively managed, and staff feedback tended to support this finding.
* The only identified care planning document which indicated issues with the recording of drug allergy information has been assessed earlier in Requirement 3 (3) (a), where I outlined my reasons for accepting the provider’s explanation of that incident.
* The Assessment Team relied upon just two instances of negative representative feedback to support their ‘not met’ recommendation. However, the provider’s response addressed that evidence satisfactorily. The provider described comprehensive fall prevention strategies in place for Consumer C. In relation to Consumer A, the consumer’s pain and pressure injury risk was otherwise managed and the late provision of an air mattress does not displace the overall positive outcomes of staff interviews, documentation review and the half of sampled consumer representatives who provided positive feedback in relation to this Requirement.
* Although the provider did not address concerns regarding call bell response times, I have addressed this evidence in Requirement 7 (3)(a).

For the reasons detailed above, I disagree with the Assessment Team’s findings and instead, find Harbour Quays Residential Aged Care to be compliant with Standard 3 Requirement (3)(b).

### Requirement 3(3)(c) Compliant

*The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved.*

The Assessment Team found the service was Non-compliant with this Requirement because although the service demonstrates that consumers nearing EOL had their dignity preserved, care provided during this time may not have been in accordance with their preferences and needs as consumer EOL plans and ACPs were not up to date. Relevant summarised evidence included:

* Consumer feedback indicated that one representative had asked to complete EOL planning with management however had not received any response to the request.
* Another representative confirmed that there had been no further discussion of his mother’s EOL wishes since the start of the pandemic.
* Staff were able to describe and give practical examples of how care changes when a consumer is nearing EOL and how their comfort is prioritised. Staff described the extra checking afforded to consumers in palliative care and management explained that EOL and ACP wishes of consumers are recorded on entry to the service if they choose, however were not subsequently updated. Refer to previous information outlined at Standard 2, Requirement (3) (b) for further information.

Based on the evidence (summarised above), the Assessment Team recommended that the service was Non-compliant with this Requirement. In their response to the Site Audit Report, the Approved Provider:

* Referred to their earlier arguments led under Requirement 2 (3)(d), noting their reliance on the same representative feedback, without providing evidence of any consumer not having their EOL needs, goals and preferences recognised and met.
* Argued the Assessment Team assumed that all consumers want to regularly update their ACP documents.
* Asserted that the Site Audit Report contains contradictory statements and conflates EOL planning and ACP processes.
* Outlined the suite of policies and procedures in place at the service to guide staff and practice in the provision of EOL care.
* Noted the service completes an after-death audit for every consumer who passes away at the service.
* Provided example EOL documentation for a consumer who had recently passed away at the service and
* Provided an email of positive feedback from a representative whose relative had recently passed away at the service.

Based on review of the Assessment Team’s findings, the Approved Provider’s response (summarised above) and my previous decision under Requirement 2 (3)(b), I disagree with the Assessment Team’s recommendation of ‘not met’ in relation to this Requirement. I find that the wording of this Requirement emphasises the actual outcomes and EOL experiences of consumers at the service, rather than focussing on the outcomes of assessment and planning for EOL that is the focus of Requirement 2 (3)(b).

I note that staff were able to describe how care delivery changes in the end of life period, and that all sampled consumer care planning documentation contained consumer wishes and/or EOL considerations, though two of those consumer’s plans were not up to date, as discussed in Requirement 2 (3)(b). I also note the Assessment Team’s overall finding that consumers who are nearing EOL have their dignity preserved. The Assessment Team did not lead any evidence that consumers who had reached the end of their lives at the service had not had the end of life experience they wanted, while the Approved Provider led convincing evidence in this regard.

For the reasons detailed above, I disagree with the Assessment Team’s findings and instead, find Harbour Quays Residential Aged Care to be compliant with Standard 3 Requirement (3)(c).

### Requirement 3(3)(d) Compliant

*Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner.*

The Assessment Team found the service was not compliant in relation to this Requirement. Relevant summarised evidence put forth by the Assessment Team included:

* Interviewed care staff knew service procedures for identifying and reporting changes and deterioration in a consumer to clinical staff.
* Clinical staff were knowledgeable about the reporting process they follow to notify Medical Officers when a consumer is deteriorating.
* Clinical records and care planning documentation indicated that consumer condition is monitored by registered staff and when deterioration occurs, it is mostly recognised and responded to in a timely way.
* The Assessment Team noted the presence of policies and procedures to support staff in recognising and responding to deteriorating consumers.

However, while the majority of consumer and representative feedback considered the service was responsive to consumer care needs and would manage consumer deterioration using pre-planned strategies, the representative of Consumer A reported that staff had not identified a pressure injury on that consumer, leading to it deteriorating. The Assessment Team stated that a review of Consumer A’s care plan noted that the pressure injury was identified in early November 2021 with no staging listed.

The Assessment Team also supported their not met recommendation with reference to representative feedback that Consumer A had also not been supplied with an air mattress needed to manage chronic hip and groin pain.

Based on the evidence (summarised above), the Assessment Team recommended that the service was Non-compliant against this Requirement.

In their response to the Site Audit report, the Approved Provider:

* Noted that there were multiple cited reasons as to why Consumer A was said to need an air mattress and referred to arguments led under Requirements 3(3)(a) and 3 (3)(b) which outlined the management of Consumer A’s pain.
* Advised that the pressure injury was identified by a family member, who reported to staff a reddened area of skin, in an area not readily visible. Evidence supplied by the provider confirms the timing of the pressure injury being identified and that it was recorded with a Stage 2 listing, contrary to the Assessment Team’s findings. The service conducted appropriate follow up management and care of the pressure injury, including multiple formal skin assessments and use of appropriate prevention strategies.
* Reported that a skin assessment one month later identified increased risk of pressure injuries and an air mattress was provided at that point.
* Explained that the pressure injury was the first experienced by Consumer A and had since healed following appropriate management and treatment.
* Demonstrated the service has detailed policies and procedures to guide staff in the identification and management of skin integrity issues, pressure injuries and pain management.

Based on review of the Assessment Team’s findings, the Approved Provider’s response (summarised above) and my previous decision under Requirement 3 (3)(b), I disagree with the Assessment Team’s recommendation of ‘not met’ for this Requirement. The wording of this Requirement is that deterioration or change in consumer condition is recognised and responded to in a timely manner. The Approved Provider demonstrated their appropriate response to Consumer A’s first pressure injury and their appropriate management of Consumer A’s pain. In light of this, and the fact that Consumer A’s representative feedback was not raised with management during the Site Audit, I find this representative feedback is not evidence of non-compliance with the Requirement. As the Assessment Team led no other evidence of non-compliance, I disagree with their recommendation and instead, find Harbour Quays Residential Aged Care to be compliant with Standard 3 Requirement (3)(d).

### Requirement 3(3)(e) Compliant

*Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared.*

### Requirement 3(3)(f) Compliant

*Timely and appropriate referrals to individuals, other organisations and providers of other care and services.*

### Requirement 3(3)(g) Compliant

*Minimisation of infection related risks through implementing:*

1. *standard and transmission based precautions to prevent and control infection; and*
2. *practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics.*

# STANDARD 4 COMPLIANT Services and supports for daily living

### Consumer outcome:

1. I get the services and supports for daily living that are important for my health and well-being and that enable me to do the things I want to do.

### Organisation statement:

1. The organisation provides safe and effective services and supports for daily living that optimise the consumer’s independence, health, well-being and quality of life.

## Assessment of Standard 4

The Quality Standard is assessed as Compliant as seven of the seven specific Requirements have been assessed as Compliant.

Consumers and representatives confirmed consumers are supported to participate in activities which interest them and to maintain the social and emotional connections important to them. The service demonstrated, and consumers confirmed, they receive services and supports for daily living which meet their health and wellbeing needs and allows them to live the life they choose. Consumers confirmed staff encourage their independence and help exercise their preferences, meet their spiritual needs and pursue their interests. Consumers confirmed they participate in a variety of activities inside and outside the service.

The service has effective systems to identify consumer interests and hobbies, likes and dislikes. The service captures consumer preference information and communicates it to staff and others involved in care. The service demonstrated they support emotional, spiritual and psychological wellbeing by providing one to one emotional support, monitoring consumers for signs of low mood, catering to spiritual needs and providing a wide range of internal and external social activities. The service monitors consumer engagement with the lifestyle program and provides alternatives for consumers who do not want to participate in group activities. Consumers are referred to external service providers when required, including for spiritual and social support.

Consumers’ care planning documentation showed consumers’ needs, preferences, goals and dietary requirements are documented and communicated to staff. Assessment and care plans are regularly reviewed and updated. The service has established relationships with a range of external providers and collaborates with them to ensure consumer needs are met. The service makes referrals in accordance with their organisational procedure.

Most consumers considered the meals are of adequate quantity, quality and variety, however, some consumers said the meals provided at the service do not consistently meet their dietary needs or preferences.

## Assessment of Standard 4 Requirements

### Requirement 4(3)(a) Compliant

*Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life.*

### Requirement 4(3)(b) Compliant

*Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being.*

### Requirement 4(3)(c) Compliant

*Services and supports for daily living assist each consumer to:*

1. *participate in their community within and outside the organisation’s service environment; and*
2. *have social and personal relationships; and*
3. *do the things of interest to them.*

### Requirement 4(3)(d) Compliant

*Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared.*

### Requirement 4(3)(e) Compliant

*Timely and appropriate referrals to individuals, other organisations and providers of other care and services.*

### Requirement 4(3)(f) Compliant

*Where meals are provided, they are varied and of suitable quality and quantity.*

### Requirement 4(3)(g) Compliant

*Where equipment is provided, it is safe, suitable, clean and well maintained.*

# STANDARD 5 COMPLIANT Organisation’s service environment

### Consumer outcome:

1. I feel I belong and I am safe and comfortable in the organisation’s service environment.

### Organisation statement:

1. The organisation provides a safe and comfortable service environment that promotes the consumer’s independence, function and enjoyment.

## Assessment of Standard 5

The Quality Standard is assessed as Compliant as three of the three specific requirements have been assessed as Compliant.

Consumers and representatives confirmed consumers feel safe and at home in the service. Consumers described, and were observed, accessing both indoor and outdoor areas and completing activities in various parts of the service. Consumers and representatives said the service is clean, well-maintained and safe, and described the service in positive terms. Staff know individual consumers’ favoured areas in the service and management described how changes in the service are made in consultation with consumers and their representatives.

Observations of the service environment showed it to be clean, tidy and welcoming. There are communal indoor dining and lounge areas and the layout of the service supports consumer’s independence, mobilisation and room identification. Consumer rooms are personalised with furniture, artwork and photographs. Consumer rooms are modern and fitted with suitable furnishings and ensuite bathrooms.

There are preventative and reactive maintenance systems in place, using in-house staff and external contractors, to ensure the environment and equipment are clean and maintained. Consumer shared equipment, furniture and fittings were clean, appeared well-maintained and fit for use. Consumers confirmed that the service’s equipment is well maintained, and problems fixed quickly. The call-bell system was observed to be operating effectively.

## Assessment of Standard 5 Requirements

### Requirement 5(3)(a) Compliant

*The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function.*

### Requirement 5(3)(b) Compliant

*The service environment:*

1. *is safe, clean, well maintained and comfortable; and*
2. *enables consumers to move freely, both indoors and outdoors.*

### Requirement 5(3)(c) Compliant

*Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer.*

# STANDARD 6 COMPLIANT Feedback and complaints

### Consumer outcome:

1. I feel safe and am encouraged and supported to give feedback and make complaints. I am engaged in processes to address my feedback and complaints, and appropriate action is taken.

### Organisation statement:

1. The organisation regularly seeks input and feedback from consumers, carers, the workforce and others and uses the input and feedback to inform continuous improvements for individual consumers and the whole organisation.

## Assessment of Standard 6

The Quality Standard is assessed as Compliant as four of the four specific requirements have been assessed as Compliant.

Consumers and representatives confirmed they know how to provide feedback and raise complaints and are comfortable to use the various complaints and feedback mechanisms at the service. Consumers and representatives said when complaints are made to the service, they are resolved to their satisfaction in a timely manner.

The service demonstrated it has effective complaints and feedback systems which supports the service’s Continuous Improvement Plan (CIP). Staff are supported to engage in continuous improvement actions and are advised of continuous improvement outcomes. A complaints register is maintained which assists management to identify trends and areas for improvement. The complaint register showed complaints are recorded, including the actions taken, the outcome and the consultation with the person who made the complaint.

The service has an open disclosure policy which states a commitment to a 'positive, blame-free, resolution-focused culture,’ and staff receive open disclosure training. Consumers provided examples of how staff addressed complaints they have raised, and the service demonstrated that recent complaints have been resolved in line with service policy and procedure, and then documented in the service’s CIP.

Based on the evidence (summarised above), the Quality Standard is assessed as met.

## Assessment of Standard 6 Requirements*.*

### Requirement 6(3)(a) Compliant

*Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints.*

### Requirement 6(3)(b) Compliant

*Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints.*

### Requirement 6(3)(c) Compliant

*Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong.*

### Requirement 6(3)(d) Compliant

*Feedback and complaints are reviewed and used to improve the quality of care and services.*

# STANDARD 7 NON-COMPLIANT Human resources

### Consumer outcome:

1. I get quality care and services when I need them from people who are knowledgeable, capable and caring.

### Organisation statement:

1. The organisation has a workforce that is sufficient, and is skilled and qualified, to provide safe, respectful and quality care and services.

## Assessment of Standard 7

The Quality Standard is assessed as Non-compliant as one of the five specific requirements have been assessed as Non-compliant.

The Assessment Team recommended Requirement (3)(a) this Standard as Non-compliant. Based on the evidence in the Assessment Team’s report and the Approved Provider’s response, I find the service Non-compliant with Requirement (3)(a). I have provided detailed reasons for my decision in the relevant Requirement below.

The Assessment Team also recommended Requirement (3)(d) this in Standard as Non-compliant. Based on the evidence in the Assessment Team’s report and the Approved Provider’s response, I disagree with the Assessment Team and find the service Compliant with Requirement (3)(d). I have provided detailed reasons for my decision in the relevant Requirement below.

Consumers and representatives mostly considered that staff were kind, gentle and caring in their dealings with consumers, and the Assessment Team’s observations were consistent with this feedback.

The service demonstrated the workforce is competent, with consumers expressing their confidence in permanent staff. The service demonstrated they have processes to monitor staff performance and ensure initial and ongoing training is provided to staff. Regular infection control, emergency and workplace safety training is evidenced in the service’s staff training records. The service’s CIP sets out periodical reviews of staff training, and the service has also annual performance appraisals.

## Assessment of Standard 7 Requirements

### Requirement 7(3)(a) Non-compliant

*The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services.*

The Assessment Team found that although management provided evidence of sufficient numbers and mix of skills in the workforce, consumer feedback and physical observations indicated the workforce numbers and mix of staff do not always enable the service to deliver and manage safe and quality care. Relevant summarised evidence included:

* The representative for Consumer G stated he had fallen several times while trying to self-mobilise in the lounge room when there was no one to supervise him. The representative stated that Consumer G had hit his head in one such fall and was transported to hospital.
* Eight of the ten consumers and representatives sampled stated dissatisfaction with staff levels and the resulting limitations on the care staff can provide.
* Six of ten sampled consumers and representatives expressed dissatisfaction with care received from agency staff.
* Staff interviewed stated they aim to cancel call bells rapidly and then provide care to the consumer when they have time.
* Management acknowledged the use of a “higher than preferred” number of agency staff and extended call bell wait times and gave evidence to show staffing concerns were being addressed via the service’s CIP.
* Call bell sensor mat records show numerous wait times longer than the target seven-minute response time.
* The Assessment Team observed Consumer I, who has a high falls risk, to call for assistance for more than 25 minutes. Staff were attending to other consumers within earshot during that time. The consumer’s care plan notes a need for a fast call bell response to minimise their risk of falls.

In their response to the Assessment Team’s report, the provider put forth the following arguments and evidence:

* In relation to Consumer G, the provider gave an account of the consumer’s care plan and the current falls prevention strategies in place. However, the provider’s response noted that Consumer G requires “close supervision” by staff when sitting on “toilet/chair/sofa/wheelchair” as the Consumer is prone to self-mobilising. The provider confirmed there had been a recent fall resulting in transportation to hospital to have a head laceration glued. An investigation of the incident found staff were “momentarily unavailable as they were attending to other consumers who needed staff assistance at the time, noting that 1:1 care and supervision of [Consumer G] cannot be expected nor supported.” The Approved Provider supplied no evidence of the investigation, such as an investigation report, or specific details about staff to consumer ratios at the time.
* In relation to concerns around use of agency staff raised by consumers and representatives, the Approved Provider detailed, at length, the current human resources challenges faced by the sector, stemming from worker shortages and the pandemic. They argued that the presence of a Commonwealth surge workforce plan that relies on agency staff demonstrates it is significantly more necessary to use agency staff at the moment.
* The Approved Provider advised they had interviewed the manager who acknowledged concerns around agency staffing and call bell response times to the Assessment Team. They issued a clarification on the manager’s behalf stating that they had not intended to convey the use of agency staff was inappropriate or in any way non-compliant with the Quality Standards, or that there were any systemic issues with call bell response times.
* In relation to Consumer I, the response argued that the consumer gets verbally agitated and vocalises, and may have been doing this, rather than explicitly calling for assistance during the Site Audit. They advised that Consumer I’s care plan contains diversionary strategies to manage this.
* The Approved Provider gave no specific response to findings that call bell sensor mat records showed frequent call bell response times exceeding the target seven-minute timeframe during times of low staffing such as weekends and evenings. Rather, they addressed Site Audit Report findings about numerous extended call bell response times. The Approved Provider supplied a call bell data report for November and December 2021, which showed that there was a spike in call bell response times that exceeded ten minutes, during the week 15 November 2021- 22 November 2021, which was reported to be a result of a technological issue.
* The Approved Provider took issue with the Assessment Team’s finding that staff cancelled call bells prior to providing care (expect in emergency situations), explaining that this was a preferable approach when there were multiple consumer call bells to attend to simultaneously. They argued this allows staff to determine the priority to be given to consumer requests.
* The provider has adopted the use of an online platform that allows existing staff to be notified of vacant shifts in real time, so they may fill them.

Based on review of the Assessment Team’s findings and the Approved Provider’s response (summarised above) I agree with the Assessment Team’s recommendation and find the service to be Non-compliant with this Requirement, for the following reasons:

* The provider led no evidence of their investigation into Consumer G’s fall, resulting in his transportation to hospital with a head laceration. It is not clear what the staff to consumer ratios were in the area where the incident occurred and as a result, it is not clear whether care and services were supplied in accordance with the care plan.
* I do not agree with the provider’s argument that staff cancelling call bells before providing care is a necessary part of triaging simultaneous bells. It should be possible for staff to attend to a consumer, acknowledge their bell verbally and then cancel it later, after they have fulfilled the request. I find that the practice of cancelling bells prior to fulfilling requests throws the overall call bell data into question.
* The provider did not respond to evidence about call bell sensor mat records with longer than target response times on weekends and evenings. This information was sufficiently particularised for the provider to provide context or explanation, but none was provided.
* I accept staff and Management feedback as it was provided to the Assessment Team, rather than the clarified version provided in the response, as on balance, it is more likely to be an impartial account.
* I accept the Assessment Team’s observations that Consumer I was either calling for help or vocalising for at least 25 minutes with no response from staff who I accept were within earshot. I note that even if Consumer I were just generally vocalising, rather than explicitly seeking assistance, none of the diversionary or other strategies identified in her care plan were implemented by staff during the time the Assessment Team were observing.
* I accept the quantitative evidence provided by the Assessment Team, which stated that most sampled consumers and representatives were dissatisfied with staffing levels and care provided by agency staff. This quantitative data, when considered alongside the qualitative consumer/ representative data in this and other Requirements, the potentially skewed call bell data, and the staff and management feedback provided to the Assessment Team on the day, tends to suggest that staff numbers and mix were not always sufficient to enable the delivery of safe and quality care.

For the reasons detailed above, I find Harbour Quays Residential Aged Care to be Non-compliant with Standard 7 Requirement (3)(a).

### Requirement 7(3)(b) Compliant

*Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity.*

### Requirement 7(3)(c) Compliant

*The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles.*

### Requirement 7(3)(d) Compliant

*The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.*

The Assessment Team found that although management demonstrated strategies and processes for recruiting, training and managing the performance of staff, consumer and representative feedback indicated overall dissatisfaction with the skills and training of agency staff. Relevant summarised evidence included:

* Two sampled consumers expressed that the quality of agency staff was lower overall than that of permanent staff and permanent staff spend extra time addressing errors made by agency staff.
* One consumer mentioned that agency staff contradict permanent staff at times.
* Interviewed care staff advised low staff numbers result in them having more stress and less time to update consumer files, and mistakes made by agency staff often cause problems and take up extra resources in re-training.
* Management acknowledged they would prefer to use less agency staff than they do but noted they have good rapport of with agencies and request the same agency staff are deployed as much as possible.
* The service has a training partnership in place to make use of student placements.
* Staff were aware of training and education opportunities available to them.
* The Assessment Team found evidence of adequate recruitment and selection systems to complete workforce checks, including police and reference checks.
* Agency staff are oriented using a checklist that takes in workplace procedures and processes and consumer handover, care and risk information.

In their response to the Assessment Team’s report, the provider:

* Argued that negative consumer feedback about the quality of agency staff were “bare and general assertions.” Representative feedback concerning agency staff contradicting permanent staff was not addressed in the response.
* In relation to concerns raised about the quality of agency staff, the provider referred to their previous arguments about the current workforce crisis affecting the sector and asserted that their preferred agency provider is an industry leader who provides highly experienced staff.
* Did not respond directly to staff feedback that mistakes made by agency staff takes up time for re-training, creates stress and encroaches on time for permanent staff to update consumer care records.

Based on review of the Assessment Team’s findings and the Approved Provider’s response (summarised above) I disagree with the Assessment Team’s recommendation and find the service to be Compliant with this Requirement, for the following reasons:

* Two pieces of consumer and representative feedback that underpinned the Non-compliant recommendation were satisfactorily addressed by the Approved Provider in their response to the Site Audit Report.
* While three other pieces of consumer and representative feedback were not satisfactorily resolved by the provider’s response, I have already considered concerns around the quality of agency staff in requirement 7 (3) (a). Consumer feedback put forth by the Assessment Team did not address the core focus areas of this Requirement, namely the recruitment, training, equipping and support of workforce.
* The remaining evidence the Assessment Team put forth to support their recommendation was positive and indicated that the service is compliant with the Requirement.

For the reasons detailed above, I find Harbour Quays Residential Aged Care to be Compliant with Standard 7 Requirement (3)(d).

### Requirement 7(3)(e) Compliant

*Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.*

# STANDARD 8 COMPLIANT Organisational governance

### Consumer outcome:

1. I am confident the organisation is well run. I can partner in improving the delivery of care and services.

### Organisation statement:

1. The organisation’s governing body is accountable for the delivery of safe and quality care and services.

## Assessment of Standard 8

The Quality Standard is assessed as Compliant as five of the five specific Requirements have been assessed as Compliant.

Consumers and representatives interviewed confirmed they are engaged in the development, delivery and evaluation of their care. Consumers and representatives confirmed their involvement in development of the service through consumer/ representative meetings, food focus groups, activities meetings and the annual consumer experience report. Most interviewed consumers confirmed staff engage them for feedback on how services and care are delivered.

The service demonstrated the governing body promotes a culture of safe, inclusive and quality care and services, and is accountable for their delivery. Mechanisms in place to support this include monthly quality meetings between the governing body and management, support in keeping abreast of regulatory changes and regular internal audits conducted by management.

The service is supported by the wider organisation and demonstrated the presence of organisation-wide systems to manage and monitor the provision of care and services. The service demonstrated they effectively implement the organisation’s governance systems, including information management, continuous improvement, feedback and complaints, financial governance, workforce governance and regulatory compliance, including meeting reporting requirements. The governing body monitors the service’s performance against the Quality Standards through monthly reporting, and the service has a CIP which aligns with the Standards.

The service has effective risk management systems that identify and respond to risks associated with the care of consumers. The documented risk management framework sets out how high impact and high prevalence risks are managed; abuse and neglect of consumers is identified and managed and consumers are supported to take risks they want to take. Staff understood the Incident Management System and open disclosure.

The service has a Clinical Governance Framework, with policies and procedures relating to antimicrobial stewardship, minimising use of restraints and open disclosure policy. The governing body has responsibility for maintaining and updating the Clinical Governance Framework and ensuring staff have accountabilities. Staff confirmed they received training on policies relating to antimicrobial stewardship, minimising the use of restraint, and open disclosure

## Assessment of Standard 8 Requirements

### Requirement 8(3)(a) Compliant

*Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement.*

### Requirement 8(3)(b) Compliant

*The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery.*

### Requirement 8(3)(c) Compliant

*Effective organisation wide governance systems relating to the following:*

1. *information management;*
2. *continuous improvement;*
3. *financial governance;*
4. *workforce governance, including the assignment of clear responsibilities and accountabilities;*
5. *regulatory compliance;*
6. *feedback and complaints.*

### Requirement 8(3)(d) Compliant

*Effective risk management systems and practices, including but not limited to the following:*

1. *managing high impact or high prevalence risks associated with the care of consumers;*
2. *identifying and responding to abuse and neglect of consumers;*
3. *supporting consumers to live the best life they can*
4. *managing and preventing incidents, including the use of an incident management system.*

### Requirement 8(3)(e) Compliant

*Where clinical care is provided—a clinical governance framework, including but not limited to the following:*

1. *antimicrobial stewardship;*
2. *minimising the use of restraint;*
3. *open disclosure*

# Areas for improvement

Areas have been identified in which improvements must be made to ensure compliance with the Quality Standards. This is based on non-compliance with the Quality Standards as described in this performance report.

Standard 2:

* Ensure consumer End of Life and/ or Advanced Care Planning documentation is up to date and follow up with consumer representatives regarding outstanding paperwork occurs in a timely manner.
* Ensure the outcomes of assessment and planning, and all consumer information, is readily available at the point of service delivery.

Standard 7:

* Improve call bell response practices, including the early cancelling of call bells.
* Improve attention to training and orientation of agency staff and seek out and monitor consumer satisfaction with standards of care provided by agency staff.
* Ensure there are high enough staff to consumer ratios to satisfy requirements for consumers with increased supervision needs.