Philip Kennedy Centre

Performance Report

Kennedy Court   
LARGS BAY SA 5016  
Phone number: 08 8242 0122

**Commission ID:** 6090

**Provider name:** Southern Cross Care (SA, NT & VIC) Inc.

**Assessment Contact - Site date:** 17 June 2020

**Date of Performance Report:** 29 July 2020

# Publication of report

This Performance Report **may 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

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| --- | --- |
| **Standard 1 Consumer dignity and choice** | **Compliant** |
| Requirement 1(3)(c) | Compliant |
| **Standard 3 Personal care and clinical care** | **Compliant** |
| Requirement 3(3)(a) | Compliant |
| Requirement 3(3)(b) | Compliant |
| Requirement 3(3)(e) | Compliant |
| **Standard 6 Feedback and complaints** | **Compliant** |
| Requirement 6(3)(d) | Compliant |
| **Standard 7 Human resources** | **Compliant** |
| Requirement 7(3)(a) | Compliant |
| Requirement 7(3)(c) | Compliant |
| **Standard 8 Organisational governance** | **Compliant** |
| Requirement 8(3)(c) | Compliant |

# Detailed assessment

This performance report details the Commission’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 Assessment Contact - Site; the Assessment Contact - Site report was informed by site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others.

# 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 one of the six specific Requirements has been assessed as Compliant.

The purpose of the Assessment Contact was to assess the performance of the service in relation to Requirement (3)(c) in this Standard. This Requirement was found Non-Compliant following a Site Audit conducted on 3 December 2019 to 6 December 2019.

The Assessment Team recommended Requirement (3)(c) in Standard 1 as met. I have considered the Assessment Team’s findings and the evidence documented in the Assessment Team’s report to come to a view of compliance with Standard 1 and find the service is Compliant with Requirement (3)(c).

At a Site Audit conducted 3 December 2019 to 6 December 2019, in relation to Standard 1, Requirement (3)(c), the Decision Maker found the service was not effectively supporting consumers to self-administer medications and consumers’ wishes in relation to who they wish to be involved in decisions about their care had not been captured.

The service has implemented a range of actions to address the deficiencies identified which I have detailed below.

## Assessment of Standard 1 Requirements

### 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.*

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the service’s last assessment and have recommended this Requirement as met. The Assessment Team’s report outlined the following actions and improvements implemented since the Site Audit, including:

* Management said improvements have been made to the organisation’s care planning processes. This includes ensuring the specialised nursing needs of consumers are captured in organisational monitoring processes, including supporting consumers to self-medicate.
* Management said the organisation utilises a culture of ‘Partners in Care’ to involve consumers and their elected representative in all decision-making and care planning. Consumers are invited to nominate the ‘next most important person’ who is to be involved in all aspects of clinical care decision making. This was confirmed by the Assessment Team through interviews with staff and documentation.

In relation to Standard 1 Requirement (3)(c), a sample of consumer files viewed, and information provided to the Assessment Team by consumers, representatives and staff through interviews demonstrated:

* Consumers interviewed said they are able to make decisions about their care and services, including what activities they participate in, being able to participate in the delivery of their care in consultation with staff, and doing things for themselves.
* Consumers described how the service has assisted them to remain mobile and to keep in contact with their family and friends during the COVID-19 outbreak. This has included keeping in contact electronically, through window visits and limited face to face visits.
* Management said the service has systems and processes in place to confirm consumers and/or their representatives are being involved in decision-making and are satisfied with the care provided. This includes involvement in care plan reviews and re-assessments, as well as regular auditing.
* Staff said they actively support and encourage consumers to exercise choice and independence on a daily and ongoing basis. This includes involvement in consumers’ care plan reviews and re-assessments. Staff described individual preferences of consumers and said care plans are amended to reflect the changing needs and preferences of consumers. Staff said they are aware of who to contact in the case of an emergency.
* Documentation, including consumer profile summaries and care plans, identified consumers’ individual preferences in relation to their care and services. Progress note documentation confirmed consumers and representatives have been involved in decision making and care consultations.

For the reasons detailed above, I find the approved provider, in relation to Phillip Kennedy Centre, does comply with Requirement (3)(c) of Standard 1.

# 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 three of the seven specific Requirements have been assessed as Compliant.

The purpose of the Assessment Contact was to assess the performance of the service in relation to Requirements (3)(a), (3)(b) and (3)(e) in this Standard. These Requirements were found Non-Compliant following a Site Audit conducted on 3 December 2019 to 6 December 2019.

The Assessment Team recommended Requirements (3)(a), (3)(b) and (3)(e) in Standard 3 as met. I have considered the Assessment Team’s findings and the evidence documented in the Assessment Team’s report to come to a view of compliance with Standard 3 and find the service is Compliant with Requirements (3)(a), (3)(b) and (3)(e).

At a Site Audit conducted 3 December 2019 to 6 December 2019, in relation to Standard 3, Requirements (3)(a), (3)(b) and (3)(e), the Decision Maker found the service:

* was not effectively optimising the health and well-being of consumers or providing effective colostomy management for consumers.
* effectively managing behaviours or ensuring safe medication management for consumers.
* had not effectively communicated and/or documented the wishes of representatives resulting in consumers being transferred to hospital or that representatives were provided with sufficient information in relation to injuries sustained by their relative from a fall.
* document all specialist’s recommendations relating to management of consumers’ behaviour in a care plan to assist staff to deliver effective care and services.

The service has implemented a range of actions to address the deficiencies identified which I have detailed below.

### 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’s report provided evidence of actions taken to address deficiencies identified in the service’s last assessment and have recommended this Requirement as met. The Assessment Team’s report outlined the following actions and improvements implemented since the Site Audit, including:

* The service provided staff with training on colostomy care, including a further training session in February 2020 for those staff who were previously on leave.
* Individual care plans have been updated to reflect the preferences of the consumers, including those consumers requiring colostomy care.
* The Ostomy care procedure has been updated and an ostomy clinical competency tool completed by all Registered and Enrolled staff. Staff confirmed they have had training in colostomy care.
* Continence reviews, including reviews by medical officers, and care consultations have been implemented for those consumers identified as requiring further strategies relating to their continence management.

In relation to Standard 3 Requirement (3)(a), a sample of consumer files viewed, and information provided to the Assessment Team by consumers, representatives and staff through interviews demonstrated:

* Consumers said they get the care they need in a manner which suits their preferences. This included staff assisting consumers with colostomy care and stoma management.
* Representatives said that despite the COVID-19 restrictions, staff have been providing excellent care to family members, including keeping representatives informed on their family members’ status. Representatives said consumers’ pain and continence is being well managed.
* Clinical and care staff described their knowledge of clinical practices in line with organisational guidelines and policies. This included how personal and clinical care is tailored to meet the needs of each consumer. Staff provided examples of individual strategies for the management of consumers’ continence and challenging behaviours. The interventions have been developed in partnership with consumers’ families and support from the external dementia organisations.
* Management said care practices have been reviewed through staff training, and information disseminated to staff through handover, staff memoranda and audits.
* The organisation has up to date policies, procedures and guidelines to ensure care is best practice. Staff said they are aware of the policies and described how to access the information.

For the reasons detailed above, I find the approved provider, in relation to Phillip Kennedy Centre, does comply with Requirement (3)(a) of Standard 3.

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

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

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified in the service’s last assessment and have recommended this Requirement as met. The Assessment Team’s report outlined the following actions and improvements implemented since the Site Audit, including:

* The service has implemented a partnership process with consumers and representatives in relation to behaviour management. As required, this may include the referral and review by external behaviour management specialists and multi-disciplinary case conferences.
* Education has been provided to all staff in dementia and behaviour management in December 2019 and January 2020. The service has introduced staff as dementia champions.

In relation to Standard 3 Requirement (3)(b), a sample of consumer files viewed, and information provided to the Assessment Team by consumers, representatives and staff through interviews demonstrated:

* Clinical staff said consumers identified with high impact and high prevalence risks, are identified through screening and assessment tools, either on admission, at care plan reviews, or following an incident or change in health status. Where a risk is identified, staff perform risk assessments and develop care plans in consultation with consumers and/or representatives. Staff provided examples of strategies in place for specific consumers in relation to weight management and diabetes management.
* A review of care documentation and interviews with staff confirmed that identified strategies are effective in the management of consumers’ behaviours.
* Incident report documentation confirmed consumers who have had an unwitnessed fall, have been assessed by a Registered Nurse and Medical officer, neuro-observations commenced and a review of the consumer’s care plan.
* Management have weekly clinical meetings and a daily review of progress notes by care managers identifies consumers who may require follow-up or interventions to be put in place.
* The service collates clinical incidents in a monthly report which is forwarded to Head Office staff for analysis, trending and review.

For the reasons detailed above, I find the approved provider, in relation to Phillip Kennedy Centre, does comply with Requirement (3)(b) of Standard 3.

### 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.*

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified in the service’s last assessment and have recommended this Requirement as met. The Assessment Team’s report outlined the following actions and improvements implemented since the Site Audit, including:

* Consumers are encouraged to participate in Advanced Care Planning, particularly for those consumers at risk of requiring hospitalisation, to ensure their end of life wishes are met. Management said that requests not to transfer a consumer to hospital require a resuscitation plan countersigned by a Medical officer.
* Management said that representatives are notified by staff of any incidents which may occur to a consumer. This should include advising representatives of the injuries sustained. On occasions when staff have not advised representatives of the injuries sustained, the service has apologised.
* Consumers’ care plans are to be updated following an incident, to include all specialist’s behaviour management recommendations. This information is communicated to staff.
* Education was provided to staff in relation to advanced care directives and end of life care in December 2019 and January 2020.

In relation to Standard 3 Requirement (3)(e), a sample of consumer files viewed, and information provided to the Assessment Team by consumers, representatives and staff through interviews demonstrated:

* Consumers said they were confident their needs and preferences are communicated to staff.
* Staff confirmed they have access to electronic care documentation, including care plans, and have sufficient information about the consumers to undertake their role.
* Staff said there are various methods of communication, including handover, emails, and memoranda. Staff interviewed were complimentary of the communication processes used by the service and reported effective interactions with allied health and the wider multi-disciplinary team.
* Care plan documentation showed that each consumer’s condition, needs and preferences have been identified, shared internally and externally and informs the delivery of care.
* Care information from internal and external agencies, including wound specialists, physiotherapists, Dementia Support Australia and Medical officers is reviewed, recorded in the service’s electronic care files and communicated to staff.

For the reasons detailed above, I find the approved provider, in relation to Phillip Kennedy Centre, does comply with Requirement (3)(e) of Standard 3.

# 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 one of the four specific Requirements has been assessed as Compliant.

The purpose of the Assessment Contact was to assess the performance of the service in relation to Requirement (3)(d) in this Standard. This Requirement was found Non-Compliant following a Site Audit conducted on 3 December 2019 to 6 December 2019.

The Assessment Team recommended Requirement (3)(d) in Standard 6 as met. I have considered the Assessment Team’s findings and the evidence documented in the Assessment Team’s report to come to a view of compliance with Standard 6 and find the service is Compliant with Requirement (3)(d).

At a Site Audit conducted 3 December 2019 to 6 December 2019, in relation to Standard 6, Requirement (3)(d), the Decision Maker found the service did not adequately demonstrate feedback and complaints are reviewed and used to improve the quality of care and services.

The service has implemented a range of actions to address the deficiencies identified which I have detailed below.

## Assessment of Standard 6 Requirements

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

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

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified in the service’s last assessment and have recommended this Requirement as met. The Assessment Team’s report outlined the following actions and improvements implemented since the Site Audit, including:

* The service has re-introduced a verbal feedback log to assist staff to capture feedback from consumers and representatives. Staff said they have been provided with training and discussions held at staff meetings on capturing verbal feedback. As a result, verbal feedback is being capture by staff.
* The service has increased the number of feedback boxes and has placed them in the common areas throughout the service.
* A separate log for COVID-19 related complaints has been implemented. These complaints are managed by the corporate management team.
* A feedback forum and a satisfaction survey were completed in March 2020 by 100% of consumers and/or their representatives to evaluate improvements made by the service following the December 2019 Site Audit. Documentation confirmed respondents were satisfied with the care and services provided, including the management of complaints.
* Resident meetings have been re-structured to enable consumers to attend meetings based on two pods. Following the success of this format, the service is further splitting the service into three pods. This will enable consumers to attend meetings and to provide feedback on their specific area.
* A copy of the meeting minutes is provided to each consumer or their representative to ensure all consumers are aware of the discussions held and the information provided. Consumers who are unable to attend the meetings can provide feedback through staff or feedback forms.
* Additional audits have been undertaken and scheduled to ensure feedback systems are effective.

In relation to Standard 6 Requirement (3)(d), a sample of consumer files viewed, and information provided to the Assessment Team by consumers, representatives and staff through interviews demonstrated:

* Complaints made directly to staff are captured as verbal complaints on the service’s feedback register.
* Consumers are encouraged to provide written complaints through the service’s feedback form or email.
* Consumers are able to raise any concerns or complaints through meetings and surveys and these are captured on the service’s feedback register.
* Management review all feedback and respond to the person providing the feedback. If required, concerns of a serious nature or those complaints which are unable to be resolved directly with the complainant, are escalated to corporate management.
* Advocacy services are utilised where a need is identified either by the consumer and/or representative, or by the service.
* Complaints are trended, analysed monthly and reported to the Board for monitoring purposes.

For the reasons detailed above, I find the approved provider, in relation to Phillip Kennedy Centre, does comply with Requirement (3)(d) of Standard 6.

# STANDARD 7 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 Compliant as two of the five specific Requirements have been assessed as Compliant.

The purpose of the Assessment Contact was to assess the performance of the service in relation to Requirements (3)(a) and (3)(c) in this Standard. These Requirements were found Non-Compliant following a Site Audit conducted on 3 December 2019 to 6 December 2019.

The Assessment Team recommended Requirements (3)(a) and (3)(c) in Standard 7 as met. I have considered the Assessment Team’s findings and the evidence documented in the Assessment Team’s report to come to a view of compliance with Standard 7 and find the service is Compliant with Requirements (3)(a) and (3)(c).

At a Site audit conducted 3 December 2019 to 6 December 2019, in relation to Standard 7, Requirements (3)(a) and (3)(c), the Decision Maker found:

* nine of 20 consumers and/or representatives interviewed were not satisfied with the responsiveness or availability of staff. This was further evidenced by an observation by the Assessment Team of a consumer who was calling out for assistance for over 15 minutes.
* seven of 20 consumers and/or representatives interviewed were not satisfied with the skills and knowledge of staff undertaking care and services for consumer.

The service has implemented a range of actions to address the deficiencies identified which I have detailed below.

## Assessment of Standard 7 Requirements

### Requirement 7(3)(a) 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’s report provided evidence of actions taken to address deficiencies identified in the service’s last assessment and have recommended this Requirement as met. The Assessment Team’s report outlined the following actions and improvements implemented since the Site Audit, including:

* The service is divided into three pods, each with two areas and a mix of female and male staff. The Registered nurse in each pod has the autonomy to re-allocate staff to another pod to assist with consumers’ specific needs.
* Management said there have been changes to the staffing structure. There has been an increase to three care managers and three Registered Nurses who are now allocated within the three pods. This has increased visibility of clinical management as well as assisting with staff management.
* The Residential services manager has a budget to increase staff levels in the event of increased consumer acuity.
* Staff are allocated to work with specific consumers for a minimum of two consecutive days. Staff confirmed they usually work in the same pod and with the same consumers, which has assisted to establish positive relationships between consumers, their representatives and colleagues.
* A high-risk resident resolution survey was conducted with 12 consumers which indicated all were satisfied with the care and services provided by the service.
* The service introduced an enhanced call bell monitoring system in April 2020 which is able to provide more accurate call bell response time data.
* There is a call bell escalation process and activations are automatically forwarded to the Residential services manager after 10 minutes. The Registered Nurse monitors all call bell activations throughout their shift. Any call bell response time in excess of 10 minutes is addressed with the consumer and the staff member prior to shift handover. This process was confirmed by Registered Nurse staff.

In relation to Standard 7 Requirement (3)(a), a sample of consumer files viewed, and information provided to the Assessment Team by consumers, representatives and staff through interviews demonstrated:

* Consumers said staff are kind and caring. None of the consumers interviewed said there were inadequate staff numbers.
* While consumers interviewed were generally satisfied with call bell response times, one consumer said they were not satisfied with the delay in responding to their call bell. This concern was raised with management who said they had spoken with the consumer and would assess the consumer for a neck pendant. The consumer was satisfied with the actions undertaken by management.
* One consumer said they prefer to have female staff attend to their care needs and said the service is responsive to their request.
* Staff interviewed said they usually have sufficient time in which to complete their work.
* Call bell response time data confirmed the service undertakes monthly call bell analysis and follows up with consumers and staff.

For the reasons detailed above, I find the approved provider, in relation to Phillip Kennedy Centre, does comply with Requirement (3)(a) of Standard 7.

### 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.*

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified in the service’s last assessment and have recommended this Requirement as met. The Assessment Team’s report outlined the following actions and improvements implemented since the Site Audit, including:

* Consumers interviewed said they were confident that staff have the appropriate skills to meet their care needs.
* A care worker competency tool has been completed by all care staff.
* An education strategy has been implemented to confirm staff knowledge and skills for both clinical and care staff. This has been completed by 100% of staff.

In relation to Standard 7 Requirement (3)(c), a sample of consumer files viewed, and information provided to the Assessment Team by consumers, representatives and staff through interviews demonstrated:

* Staff said they have annual appraisals and are encouraged to submit suggestions for their professional development, feel supported to perform their role and are satisfied with the quality and quantity of formal and informal training provided.
* Management said the service has a system of continuous assessment of staff. Staff are monitored by their line manager and additional guidance and/or training provided as appropriate.
* Documentation confirmed staff complete competency assessments which are completed at the time of their annual reviews with their line managers. Consumers are involved in the staff competency assessment and are invited to provide feedback on a staff member’s abilities and interactions with them during the provision of direct care.

For the reasons detailed above, I find the approved provider, in relation to Phillip Kennedy Centre, does comply with Requirement (3)(c) of Standard 7.

# 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 one of the five specific Requirements has been assessed as Compliant.

The purpose of the Assessment Contact was to assess the performance of the service in relation to Requirement (3)(c) in this Standard. This Requirement was found Non-compliant following a Site audit conducted on 3 December 2019 to 6 December 2019.

The Assessment Team recommended Requirement (3)(c) in Standard 8 as met. I have considered the Assessment Team’s findings and the evidence documented in the Assessment Team’s report to come to a view of compliance with Standard 8 and find the service is Compliant with Requirement (3)(c).

At a Site Audit conducted 3 December 2019 to 6 December 2019, in relation to Standard 8, Requirement (3)(c), the Decision Maker found not all reportable assault incidents were being logged on the mandatory reporting register in line with legislative requirements. The Decision Maker did find the organisation adequately demonstrated effective governance systems in relation to information management, continuous improvement, financial governance, workplace governance and feedback and complaints.

The service has implemented a range of actions to address the deficiencies identified which I have detailed below.

## Assessment of Standard 8 Requirements

### 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.*

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified in the service’s last assessment in relation to regulatory compliance and have recommended this Requirement as met. The Assessment Team’s report outlined the following actions and improvements implemented since the Site Audit, including:

* The organisation has updated their Reportable assault procedure to ensure the name of the victim of an alleged assault is recorded on the Critical incident register.
* Incidents from December 2019 to January 2020 have been reviewed and all incidents of a critical nature have been recorded on the service’s Critical incident register.
* Education for Registered and Enrolled staff on compulsory reporting has been completed.

In relation to Standard 8 Requirement (3)(c), information provided to the Assessment Team through interviews and documentation demonstrated:

* The service maintains a consolidated log which records allegations of elder abuse and absconding in accordance with legislative requirements. A recent review of the log showed that all relevant information regarding consumers involved in incidents of this nature have been captured.

For the reasons detailed above, I find the approved provider, in relation to Phillip Kennedy Centre, does comply with Requirement (3)(c) of Standard 8.

# Areas for improvement

There are no specific areas identified in which improvements must be made to ensure compliance with the Quality Standards. The provider is, however, required to actively pursue continuous improvement in order to remain compliant with the Quality Standards.

# Other relevant matters

I note that, whilst not assessed as part of the Assessment Contact, the Assessment Team has provided information in relation to Standard 3 Requirement (3)(g).

During the Assessment Contact on 17 June 2020, the Assessment Team noted the following:

* Several wall mounted sanitiser stations located in corridors and near a lift were empty. Following the tour of the service, the Assessment Team noted that staff had placed pump sanitiser bottles by the mounted sanitiser stations as instructed by management.
* Management initially stated to the Assessment Team that the service has been refilling the hand sanitiser stations from bulk purchased sanitiser. Later management advised this was not the case as the gel packs cannot be refilled.
* Hand sanitiser options were not available to consumers or visitors in corridors or in common areas.
* Pump pack sanitisers were observed to be located behind the nurses’ station desks in some areas but not easily accessible to consumers or visitors to the service.
* Signage encouraging safe infection control practices, including handwashing and the use of hand sanitisers, was not obvious around the service.
* Staff said the stations had been empty since April 2020. No alternatives had been provided for consumers or visitors that they were aware of and that bottles of sanitisers were not located in common areas, such as lounges or dining rooms for consumers or visitors to use.
* Clinical staff said consumers were encouraged to wash their hands prior to meals at the handwashing facility in their rooms. Whilst consumers are not advised to wash or sanitise their hands after a meal or routinely, staff said they frequently wipe consumers’ hands with paper towels when visibly soiled.

The Assessment Team discussed the above with management who said they would consider how the service could further encourage recommended infection control practices. Management provided the Assessment Team with procurement documentation reflecting that sanitiser had been ordered on several occasions during March and June 2020.