St Vincent’s Care Services Hawthorn

Performance Report

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**Commission ID:** 3610

**Provider name:** St Vincent’s Care Services Ltd.

**Site Audit date:** 14 February 2022 to 16 February 2022

**Date of Performance Report:** 12 April 2022

# Performance report prepared by

Denise McDonald, 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) | Compliant |
| Requirement 2(3)(c) | Compliant |
| Requirement 2(3)(d) |  Non-compliant |
| Requirement 2(3)(e) | Compliant |
| **Standard 3 Personal care and clinical care** | **Non-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) | Non-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** | **Compliant** |
| Requirement 7(3)(a) | 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 Approved Provider’s response to the Site Audit report received on 30 March 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 6 of the 6 specific requirements have been assessed as Compliant.

Overall, consumers considered they are treated with dignity and respect, can maintain their identity, make informed choices about their care and services and live the life they choose. Consumers felt respected by staff and their identity, culture and diversity was valued. Consumers confirmed staff knew about their cultural background and what was important to them.

Staff provided specific examples of how a consumer’s culture and life story influences how they deliver care and services on a day-to-day basis. Care planning and lifestyle documents reflected the diversity of consumers including their life experiences, cultural backgrounds, needs and preferences.

The service demonstrated that consumers are supported to exercise choice and independence and take risks, should they choose to. Consumers and representatives confirmed they could exercise choice, independence and take risks to enable them to live the best life they can. The organisation has recently established and reviewed policies for Consumer Respect, Choice and Diversity and Privacy to support the requirements of this standard. These policies are supported by staff training.

Staff described how they support consumer choices and encourage independence. Staff were aware of consumers who want to take risks and provided examples of how they support them.

The organisation has a risk management framework and policies support the ‘dignity of risk’ concept that recognises consumers have the right to make decisions that affect their lives and have those decisions respected, even if there is some risk. Risk assessments are completed on entry by the clinical manager (CM) or registered nurse (RN) in consultation with consumers and their representatives. These risks are discussed with consumers and representatives and are included in care planning documents.

The service demonstrated that timely, current and accurate information is provided to consumers. Activity calendars and monthly menus were observed in consumer’s rooms and notice boards around the service displayed a range of information for consumers. Consumers and representatives advised they received timely and accurate information to assist them in making choices about their care and lifestyle, such as meal selections and daily activities.

Staff described various ways of how information is provided to consumers including through noticeboards, verbally, written communication and newsletters. Staff said consumers are asked about their preferences on an ongoing basis; at each meal and for each activity scheduled. If consumers do not speak English or have a cognitive impairment, staff advised they may use gestures, show them or use other staff or family members to help translate.

The service demonstrated that consumers’ privacy is respected, and personal information kept confidential. The service’s residential agreement and handbook contains information about privacy rights and requirements of the Privacy Act. Consumers are provided with a copy of the Charter of Aged Care Rights that includes the right to personal privacy and to have personal information protected.

Consumers and representatives were satisfied that their privacy was respected. Consumers said staff knock on the door before entering and keep doors closed when providing personal care. Staff don’t intrude when family members are there. Staff said they do not discuss consumers’ personal details in public and handover is conducted in private areas. Staff were observed delivering care and services that was respectful of consumers’ privacy. For example, staff closed doors when delivering personal care and logged out of computers that contain personal information.

## 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-COMPLIANTOngoing 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 one of the 5 specific requirements have been assessed as Non-compliant.

The Non-compliance is in relation to Requirement 2(3)(d). Reasons for the finding are detailed in the relevant Requirement below.

The Assessment Team also recommended Requirements 2(3)(a), 2(3)(b), 2(3)(c) and 2(3)(e), as not met. However, my finding differs from the recommendation and I find these Requirements compliant. Reasons for the findings are detailed in the relevant Requirements below.

While most consumers and their representatives were satisfied with the care being received, some consumers did not consider they were treated like partners in the ongoing assessment and planning of their care and services. Some consumers’ care documents did not detail their current needs, goals and preferences and did not adequately show that assessment and planning, included consideration of risks to the consumer’s health and well-being. Interim care plans and monthly reviews did not appear to always be completed in accordance with the organisation’s schedule.

The service uses a fully integrated electronic care documentation system to complete initial assessments to identify consumers’ needs, goals and preferences when they arrive at the service. A comprehensive care plan is completed once the assessment process scheduled is completed. The organisation’s policy is that the care plan is reviewed at least every 3 months and/or as consumer needs change and a consumer of the day (COD) is undertaken every month. Registered staff were able to describe how the assessment and care planning process identifies consumers’ goals, needs and preferences and is used to inform care delivery. While most care plans were current some did not appear to always be updated to reflect the recommendations of the medical officers, allied health care specialists such as speech pathologists, podiatrists and dieticians.

The service has a clinical manual which includes policies and procedures for palliative care planning, wound management and catheter care to guide staff practice. The service also documents consumers’ end of life wishes through an Advanced care plan. The service was not always able to show that the documentation around advance care planning and end of life planning was up to date and in line with consumer wishes. Clinical staff advised the care plan review process involves discussions directly with the consumers and/or their representatives. The service communicates the outcomes of all assessments with consumers and representatives and care plans are available upon request.

Staff explained how a change in a consumer’s condition or incident would trigger a reassessment and review of the care plan with any necessary changes made by clinical staff.

## 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.*

The service completes initial assessments to identify consumers’ needs, goals and preferences when they arrive at the service. A comprehensive care plan is completed once the assessment process is completed. The organisation’s expectation is that the care plan is reviewed at least every 3 months and/or as consumer needs change and a COD review is undertaken every month.

The Assessment Team found the service had not demonstrated that assessment and care planning processes were implemented to inform the delivery of safe and effective care and services. Evidence relevant to the finding included:

* The Assessment Team found some consumers care documents did not detail their initial care plan or their current needs, goals and preferences. A COD review was not always completed as per the schedule or not in accordance with the organisation’s expectations.
* One consumers record did not show a risk assessment completed for a bed pole.
* The care record of one consumer’s COD review on the 15 February 2021 appeared incomplete and a Complex Health Care Plan had not been completed in relation to their pacemaker.
* One consumer representative expressed dissatisfaction about the care information they were being provided by the service and said they hadn’t been given a copy of the consumer’s care plan. This feedback has been considered elsewhere under Requirements 2(3)(c) and 2(3)(d).

The Approved Provider’s response disputed some of the statements in the Site Audit Report and provided additional information and evidence in support of their assessment and planning processes. The Approved Provider also submitted a copy of the service’s Quality Improvement Plan which included both previously listed and new actions identified to address gaps. The Approved Provider advised:

* The service acknowledged that initial assessments had not been fully completed for a small number of recent admissions. This was attributed to disruption due to COVID-19 exposures and a series of lockdowns over the past few months.
* The service provided evidence that a dignity of risk process had been completed and documented in relation to the consumer who had a bed pole.
* The service advised the consumer’s COD review on 15 February 2021 had been completed but it did not show as completed on the system due to the checklist not being completed. The care plan did indicate the consumer had a pacemaker, but a Complex Health Care Plan had not been completed.
* The service transitioned to a new electronic care documentation system in February 2021 which meant that assessments and care plans for existing consumers all fell due around the same time. The service explained that assessments and care plans had been updated when there is a change in care needs and this has meant that a large proportion of care plans have already been updated.
* The service indicated they already had identified the gaps in the care documentation cycle and, on 22 September 2021, had put in place a plan to address this on their Quality Improvement Plan. This work was underway at the time of the audit.
* The service did not believe that the gaps in documentation had negatively impacted on the quality or safety of any consumer’s care or services.

I acknowledge the Approved Provider’s response to the Assessment Team report and the additional information and evidence in support of there being effective assessment and planning processes for care and services. I note that there was favourable feedback from staff and several consumers and their representatives in relation to assessment and planning of care and services at the service. I note that the issues around staggering the review cycle arising from the transition to the new electronic care documentation system have already been identified on the Quality Improvement Plan and corrective actions underway. I also consider it reasonable that the initial assessment and planning process may not be completed in a single session as some assessments may require investigation over some time and further consultation with specialists. I find evidence in relation to a consumer’s representative not being satisfied with communication and access to a care plan are more appropriately considered under Requirement 2(3)(d).

Having considered the evidence in the Site Audit Report and the Approved Provider’s response, I find that the service undertakes assessment and planning, including consideration of risks to consumer’s health and well-being, that informs the delivery of safe and effective care and services.

Based on the evidence summarised above, I find the service Compliant with this Requirement.

### Requirement 2(3)(b) 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 the service did not demonstrate that assessment and planning identifies and addresses the consumer’s current needs, goals, and preferences, including advance care planning if the consumer wishes. Evidence relevant to the finding included:

* Registered staff were able to describe how the assessment and care planning process identifies consumers’ goals, needs and preferences that inform the care plan development and delivery of care.
* Care documents for most consumers detailed the individual’s current needs, goals and preferences however, the Assessment Team identified two examples where it appeared the care plans were not followed. I have considered these issues under Standard 3.
* The service has a palliative care policy to guide staff practice. The service also documents consumers end of life wishes through an Advanced Care Directive (ACD).
* An ACD is voluntary and are completed manually and then uploaded onto the electronic care documentation system by administrative personnel. The Assessment Team found that not all ACD had been uploaded so staff would not have access the consumers’ end of life wishes after hours.
* While care documentation indicated consumers’ preferences in relation to resuscitation the ACD for three consumers had not been uploaded to the electronic care documentation system.
* Management said that they were aware of the need to upload completed ACDs to the electronic care documentation system and they have implemented a process to do this which is still ongoing.
* One consumer said that no one had spoken to them about end-of-life planning, and they would like to discuss it.
* Two consumers did not have ‘My Life Events’ and ‘Leisure and Lifestyle Special Considerations My Life History’ forms completed.

The Approved Provider’s response disputed some of the statements in the Site Audit Report and provided additional information and evidence in support of their assessment and planning processes. The Approved Provider also submitted a copy of the service’s Quality Improvement Plan which included both previously listed and new actions identified to address gaps. The Approved Provider advised:

* The service had completed the ACD forms for all the consumers identified by the Assessment Team and would have been able to provide evidence of this, however they were not provided with the opportunity to do so.
* Consumers and families are encouraged to complete an ACD however, where consumers or families chose not to do so, their choice is respected.
* Hard copies of completed ACD forms are kept in the consumers hard copy file and they were available at the time of the audit.
* There had been end of life discussions with the consumer that advised the Assessment Team they had not had end of life discussions. The consumer had an advanced care plan in place and an ACD which was uploaded to the electronic care documentation system on 17 November 2020. A hard copy was on the consumer’s hard copy file. A copy was submitted with the Approved Provider’s response.
* While two consumers did not have ‘My Life Events’ and ‘Leisure and Lifestyle Special Considerations My Life History’ forms completed their ‘Key to Me’ forms were completed and available for staff. I have considered this information under Requirement 2(3)(d).

I acknowledge the Approved Provider’s response to the Assessment Team report and the additional information and evidence in support of their assessment and planning procedures at the service.

I note that the Assessment Team stated that care documents for most consumers detailed the individual’s current needs, goals and preferences and feedback from several staff and consumers and their representatives was positive in relation to assessment and planning at the service. I note that Advanced Care Directives had been completed in hard copy form for all the relevant consumers. These were accessible by staff even though they may not have yet been uploaded to the electronic care documentation system. I find evidence in relation to potential gaps in the completeness of some documentation more appropriately considered under Requirement 2(3)(d).

Having considered the evidence in the Site Audit Report and the Approved Provider’s response, I find that the service’s assessment and planning process identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes.

Based on the evidence summarised above, I find the service Compliant with this Requirement.

**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.*

The Assessment Team found the service demonstrated that assessment and planning included other providers of care and services such as; medical officers, speech pathologists, dieticians, podiatrists, physiotherapists and pastoral carers. However, the Assessment Team found the service did not always demonstrate that assessment and planning is based on a partnership with the consumers and/or their representatives. Evidence relevant to the finding included:

* One consumer’s COD review on 27 January 2022 was incomplete and no evidence was found in the notes about consultation with them or their representative.
* There was no documented evidence of consultation with the consumer or their representative for two other COD reviews conducted on 11 February 2022 and 12 February 2022.
* Some consumers and their representatives reported being always involved in the assessment and planning process on an ongoing basis while three consumers and their representatives, felt they were not involved.
* One consumer representative expressed dissatisfaction about the care information they were being provided by the service and said they hadn’t been given a copy of the consumer’s care plan.
* Staff stated that monthly CODs are completed, and this included the RN reading through the last month’s notes and updating assessments and care plans, following up on any outstanding items and discussing these with the consumer and/or their representative.
* The Assessment Team observed assessments and care planning documents available and accessible via the electronic care documentation system.

The Approved Provider’s response disputed some of the statements in the Site Audit Report and provided additional information and evidence in support of their consultation in the assessment and planning process. The Approved Provider advised:

* The service does not agree that staff do not discuss care and service needs with consumers and/or representatives.
* There was no consultation on the same day with the representative in relation to the COD review conducted on the 27 January 2022 however, the service provided evidence of consultation with the representative about the consumer’s care at other times.
* There was consultation with the consumer directly in relation to their COD review on 11 February 2022 as they are capable of engaging in the discussion.
* In relation to the COD review on 12 February 2022, the service provided evidence of consultation with the consumer directly about their care and services as they are capable of engaging in the discussion. There was also evidence of a pastoral care consultation with the consumer directly on 12 February 2022.
* The service provided extensive evidence of contacts and communication with the consumer representative who expressed dissatisfaction with the communication from the service. The service was also unaware of any request from the representative for a copy of the care plan despite having had a meeting with the representative and another immediate family member on 9 February 2022.

I note that the Assessment Team found the service demonstrated that assessment and planning included other providers of care and services, but they found the service did not always demonstrate that assessment and planning is based on a partnership with the consumers and/or their representatives. In relation to the examples cited by the Assessment Team, I am satisfied there is evidence the service, had and was, engaging and partnering with consumers and representatives in relation to their care and services. I consider it reasonable that consultation and engagement with consumers and their representatives is an ongoing process and it may not always be conducted in the first attempt. I find evidence in relation to potential gaps in the completeness of some care documentation and access to care plans more appropriately considered under Requirement 2(3)(d).

Having considered the evidence in the Site Audit Report and the Approved Provider’s response, I find that the service demonstrates that assessment and planning, is based on an ongoing partnership with the consumer (and others they wish to involve) and it includes other organisations, individuals and providers of care and services.

Based on the evidence summarised above, I find the service Compliant with this Requirement.

### 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 did not demonstrate that consumers and representatives are engaged in communication regarding the outcomes of assessment and planning and that care and services plans are effectively documented and readily available to the consumer. Evidence relevant to the finding includes:

* Care planning documents were observed to be available and accessible via the electronic care documentation system.
* One consumer’s care plan was not updated to reflect the assessments and recommendations of the dental reviews in July 2021 and February 2022.
* One consumer’s care documents and medication chart were not updated to reflect a review by the dietitian and speech pathologist.
* The checklist was not completed for one consumer’s COD review on 15 February 2022 and it did not show as completed on the system. The consumer had a pacemaker and a Complex Health Care Plan had not been completed.
* Two consumers did not have ‘My Life Events’ and ‘Leisure and Lifestyle Special Considerations My Life History’ forms completed.
* One consumer representative expressed dissatisfaction about the care information they were being provided by the service and said they were not told when the doctor was coming. They said they had asked for a copy of the consumer’s care plan but hadn’t been provided with a copy.
* One representative said they had not been aware they could access their consumer’s care plan but when they requested it, it was provided.
* Management advised consumers’ care plans can be provided to consumers and representatives when requested.
* One consumer said they are always communicated with about their care and services plan.
* One representative said they always gets a COD review call and find it a good opportunity to give feedback.
* Initial clinical assessments were not always completed as per the admission schedule and 3 interim care plans were only partially completed. Two were completed during the audit after it was brought to the attention of the manager.
* One consumer’s documentation was not completed in relation to their COD review on 12 February 2022.
* Some consumers and representatives expressed their satisfaction with the information that is provided to them, and their involvement in care planning processes, however two did not.
* Care staff said they refer to handover processes both verbal and interactive handover sheet, progress notes, care plan reviews and electronic alerts via the electronic care documentation system, particularly if there had been changes in consumers’ care requirements.
* Registered staff said that the service would communicate outcomes of all care and service assessments through care plan conferences or during visits.
* Registered staff stated that all COD and care plan review processes involve discussions with the consumers and/or their representatives and were able to access care plans on the electronic care documentation system.
* Samples of Advanced Care Directive forms were poorly completed by the service with sections not being completed or annotated to indicate the specific topic had been discussed with the consumer and/or their representative.

The Approved Provider’s response disputed some of the statements in the Site Audit Report and provided additional information and evidence in support of the communication and documentation of their assessment and planning process. The Approved Provider also submitted a copy of the service’s Quality Improvement Plan which included both previously listed and new actions identified to address gaps. The Approved Provider advised:

* The service acknowledged that the assessment and care plan for one consumer was not updated to reflect the assessments and recommendations of the dental reviews in July 2021 and February 2022.
* The service stated that all interventions and actions were implemented in line with the dietitian and speech pathologist recommendations for one consumer.
* The service acknowledged that two consumers did not have ‘My Life Events’ and ‘Leisure and Lifestyle Special Considerations My Life History’ forms completed but noted their ‘Key to Me’ forms were completed and available for staff.
* The service acknowledged that there was no documented Complex Health Care Plan for the consumer with a pacemaker.
* The service acknowledged that the documentation for the COD review on 12 February 2022 did not record evidence of the care consultation with the representative 3 days prior.
* The service acknowledged that the restrictive practices forms for three consumers were incomplete.
* The service provided extensive evidence of contacts and communication with the consumer representative who expressed dissatisfaction with the communication from the service. The service was also unaware of any request from the representative for a copy of the care plan despite having had a meeting with the representative and another immediate family member on 9 February 2022.
* The service acknowledged the transition to the new electronic care documentation system in February 2021 has resulted in the review date for care files showing they are due at the same time.

Having considered the evidence in the Site Audit Report and the Approved Provider’s response, I am satisfied that the service makes the documented care and services plan available to consumers and their representatives in accordance with their policies and the Requirement. While I consider the service has demonstrated that the outcomes of assessment and planning were effectively communicated to the consumer or representative, I do not find the service has shown it effectively documents care and service plans. In the sampled material there were multiple instances where care and service documentation was missing, incomplete, not current, not in the correct field, or incorrectly scheduled.

Based on the evidence (summarised above), I find the service Non-compliant with this Requirement.

### 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.*

The Assessment Team found the service did not demonstrate it regularly reviews the care and services it provides to the consumers and that care plans are up to date and meet the consumer’s current needs. Care planning documentation did not consistently show evidence of review by staff when circumstances change. Clinical monitoring did not consistently identify when a consumer’s condition changes and a clinical review was warranted. Evidence relevant to the finding includes:

* One consumer was identified as having unplanned weight loss and they were referred to the speech pathologist and dietician. The consumer was consulted and aware of the planned treatment. Several recommendations were recorded in the consumer’s progress notes however the Assessment Team found the care plan was not adequately updated. (Evidence around the effective documentation of care and services plans have been considered under Requirement 2(3)(d) above)
* One consumer was reviewed by the dentist on 7 February 2022 with observations and recommendations made for monitoring for infection and pain. (Evidence around the effective documentation of care and services plans have been considered under Requirement 2(3)(d) above)
* One consumer was assessed by the RN and medical officer following an incident and further investigations undertaken. His care plan was reviewed and updated with recommendations to minimise the risk of reoccurrence. The records showed the representative was contacted.
* Management stated that care plans are to be reviewed 3 monthly with an annual care conference with the consumer and/or their representative. A COD process occurs monthly to review and update assessments and care plans with recent changes.
* Management said some care plans are recorded as overdue for the scheduled 3 monthly review due to the transition to the new electronic documentation system. However, all consumers are being reviewed when circumstances change or when incidents impact on their needs, goals or preferences.
* Staff interviewed demonstrated an understanding of the monthly COD process and the 3 monthly care plan evaluation process.
* Staff said they report changes or concerns with a consumer’s health to the RN. The RN assesses the consumer and may contact the medical officer if necessary and inform the consumer and/or their representative.
* Care staff said they were informed of changes to consumer care requirements via the handover process both verbal and documented as well as via the care plan.

The Approved Provider’s response disputed some of the statements in the Site Audit Report and provided additional information and evidence in support of the review of the efficacy of the care and services when circumstances change or when incidents impact on the needs, goals or preferences of the consumer.

Having considered the evidence in the Site Audit Report and the Approved Provider’s response, I find the service has demonstrated that the care and services are reviewed regularly for effectiveness, when circumstances change or when incidents impact on the needs, goals or preferences of the consumer.

Based on the evidence (summarised above), I find the service Compliant with this Requirement.

# STANDARD 3 NON-COMPLIANTPersonal 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 Non-compliant as one of the 7 specific requirements have been assessed as Non-compliant.

The Non-compliance is in relation to Requirements 3(3)(e). Reasons for the finding are detailed in the relevant Requirement below.

The Assessment Team also recommended Requirement 3(3)(a) as not met. However, my finding differs from the recommendation and I find this Requirement Compliant. Reasons for the finding are detailed in the relevant Requirement below.

Most consumers and their representatives were complimentary of the care being received. Whilst consumers and their representatives felt that they get the care they need, care documentation and staff feedback indicated did not always support this.

The service was able to demonstrate the effective management of high impact or high prevalence risks associated with the care of each consumer. Consumers are routinely assessed for pain, using an appropriate pain assessment tool. Strategies employed to minimise pain include; therapeutic massage, use of heat packs, repositioning and oral pain medication.

Staff described strategies in place to manage individual consumer’s risks such as; behaviours; pressure injuries, falls, weight loss and infection. Staff knew how to report incidents to the RN and stated they do not always complete the incident report themselves, but the RN would. Registered staff described how incidents were reviewed, and how any follow up actions are initiated.

Policies and procedures are available to staff on high impact or high prevalence risks in their Clinical Manual. The service records and trends clinical indicators monthly which include; medication incidents, falls, infections and wounds.

The service was able to demonstrate consumers who are nearing end of life have their comfort maximised and dignity preserved, and care is provided in accordance with their needs, goals and preferences. The service has a palliative care policy and procedures as well as the Clinical Manual which includes the end-of-life palliative care clinical considerations and the Comfort Care Chart. Management advised that a continuous improvement has been logged for the updating and checking of all ACDs and this process is underway.

Changes in consumer’s care needs were recognised and responded to in a timely manner. Staff could explain how they recognised and responded to a deterioration or change in a consumer’s condition. This included processes to investigate, monitor and escalate to the medical officer, as well as notify the consumer representative.

Information about the consumer’s condition, needs and preferences is not always documented and communicated within the organisation, and with others where responsibility for care is shared. Care planning documents and progress notes generally reflected the timely identification of, and response to, deterioration or changes in the consumer’s condition or health status.

The service makes timely and appropriate referral of consumers to other providers of care and services. Care planning documentation identifies a consumer’s referral to other health care providers is done as needed. Consumers and representatives were satisfied with referrals to other services and did not raise any concerns.

Staff described the process for referring consumers to other health professionals and how this informs the care and services provided to consumers. Staff stated that the service manager books all referrals and is sent an email about the outcome of the referral.

The service demonstrated it has documented policies and procedures to support the minimisation of infection related risks through the implementation of infection control principles and the promotion of antimicrobial stewardship. An outbreak management plan supported the service’s preparedness in the event of a COVID-19 outbreak.

An Infection Prevention and Control Manual was available as well as an outbreak management plan to guide staff. Staff demonstrated an understanding of infection control practices which included hand washing before and after contact with consumers, wearing appropriate Personal Protective Equipment (PPE), utilising biodegradable laundry bags for soiled linen/personal clothing, emptying continence aids into waste bins, vaccinations as prescribed, temperature checks and not attending work if any symptoms of or feeling unwell. Also, reporting to the clinical staff if the consumer showed any sign of being unwell.

Staff explained strategies to minimise the use of antibiotics such as; checking past history, encouraging fluids for suspected urinary tract infections and giving cranberry juice, monitoring vital signs, confirming pathology and reporting to the medical officer. Clinical indicators, which include infections, are monitored and discussed monthly with the Facility Manager, Quality Compliance Manager (QCM) and State Manager.

Adequate supplies of PPE were observed around the service with extra supplies available in the event of an outbreak. The service had temperature monitoring and screening processes upon entry to the service, donning and doffing stations, hand sanitiser and antibacterial wipes with signs to please wipe down high touch areas.

### 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 demonstrate that consumers generally receive safe and effective personal or clinical care, which is best practice, tailored to their needs and optimises their health and wellbeing. Evidence relevant to the finding includes:

* Generally, consumers and representatives were happy with the care and services provided and felt well looked after.
* One consumer’s oral and dental assessment and care plans were not updated to reflect a deterioration in their oral health. The dentist noted broken teeth, loose denture, tooth supporting denture noted to be ‘wobbly’ and interventions prescribed to clean the denture were with water only and not to use toothpaste. This was not reflected on the oral and dental assessment dated 5 November 2021 and staff sampled were unaware of the cleaning instructions.
* One consumer who was reviewed by the speech pathologist on 21 January 2022 was diagnosed with dysphagia and management strategies, such as appropriate positioning, were not reflected in their care plan. The diagnosis of dysphagia was not recorded in the care plan and there was no evidence that this had been communicated to the medical officer for review.
* One consumer’s care plan had not been updated following a visit from the dietician on 9 February 2022. The care plan had not been updated to reflect the prescription of supplements, nor the medication chart and there was no evidence that the medical officer had been notified of the review and recommendations. The medication chart showed the consumer had been prescribed nutritional supplement on 21 November 2021 but there was no evidence available to determine if it had been given.
* One consumer required investigation following an incident on 8 February 2022. This involved behaviour charting for 7 days and the request for a urine test to check for an infection. Following the incident there was no follow up of the urine test and it remained outstanding. This was not identified as part of the COD completed on 15 February 2022. The behaviour charting was scheduled in the appointments however the charting did not reflect any entries. The charting was not evaluated at the end of the 7 days. The incident had been noted as completed on the Incident management register.
* One consumer who was receiving chemical restraint had no behaviour support plan and recording chart in place however the medical officer attended the following day and completed it. Management advised that the previous form was archived, and restraint documentation was captured in the progress notes.
* One consumer had a pacemaker in place however the care plan and assessments do not provide guidance for staff around monitoring or any special care considerations.
* Staff could describe specific clinical and personal care needs and risks and how these were being managed or monitored (in line with their care plans).
* Three consumer’s Restrictive Practice forms were inconsistently completed and not in line with best practice.
* Wound monitoring documentation for eight consumers did not evidence wounds are consistently monitored or reviewed weekly by a RN.
* Management said that clinical indicators were tracked and trended monthly and discussed at meetings. Issues identified triggered education and corrective actions.

The Approved Provider’s response disputed some of the statements in the Site Audit Report and provided additional information and evidence in support of the provision of safe and effective personal and clinical care that is tailored to each consumer. The Approved Provider also submitted a copy of the service’s Quality Improvement Plan which included both previously listed and new actions identified to address gaps. The Approved Provider advised:

* The service stated that any documentation gaps have not resulted in any detrimental outcomes for consumers and the overall feedback from assessors was that the consumers and families are very happy with the care provided.
* The service acknowledged that wound measurements were not consistently being taken or reviewed weekly by a RN however, the service did complete all other care interventions and actions which included wound photos, referrals to wound specialist and/or medical officer and appropriate wound management treatment. There were no detrimental outcomes for consumers as evidenced by the wounds either healing or continuing to improve.
* The service provided evidence that the consumer diagnosed with dysphagia was being provided with the prescribed supplement and recommended care.
* The service acknowledged that they failed to document the result of the urine test for one consumer but provided evidence that the consumer was correctly tested, monitored and cared for. The representative was also contacted.

Having considered the evidence in the Site Audit Report and the Approved Provider’s response, I do not find that the gaps identified in documentation have adversely impacted the safety or personal and clinical care provided by the service to consumers. I have further considered the deficits in documentation identified by the Assessment Team under Requirement 3(3)(e) and Requirement 2(3)(d). I therefore find that the service has demonstrated that they provide safe and effective personal and clinical care, which is best practice, tailored to their needs and optimises their health and wellbeing.

Based on the evidence (summarised above), I find the service Compliant with this Requirement.

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

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

### 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.*

### 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.*

### Requirement 3(3)(e) Non-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 found information about the consumer’s condition, needs and preferences is not always documented and communicated within the organisation, and with others where responsibility for care is shared. This was evident with external services provided by the dietician, dentist and the speech pathologist. Evidence relevant to the finding included:

* The Assessment Team identified three instances of information not being communicated following a review from an allied health specialist.
* The consumer files sampled showed evidence in progress notes of reviews by allied health specialists however outcomes of the reviews were not always reflected on the consumers individual assessments and care plans.
* One consumer’s recent dietician and speech pathologist review was not updated in their nutrition and hydration assessment and there was no evidence that it had been printed out and given to the kitchen to meet their meal requirements.
* One consumer’s recent dental review was not communicated to care staff via the verbal or electronic hand over process or electronic alert built into the electronic care documentation system being used by the service. Staff confirmed they were not aware of dentist recommendations for care of the consumer’s denture.
* Staff explained there are various ways that information about consumer’s care and services is communicated. Clinical staff said they use an alert system and are able to flag a note for handover, turning it red and highlighting it in the notes. An interactive handover occurs at the change of each shift and changes to care, medical reviews and follow ups are discussed.

The Approved Provider’s response disputed some of the statements in the Site Audit Report and provided additional information and evidence in support of care information being documented and communicated within the service. The Approved Provider also submitted a copy of the service’s Quality Improvement Plan which included both previously listed and new actions identified to address gaps. The Approved Provider advised:

* The service acknowledged that in the case of one consumer’s dental review they did not update the assessment and care plan and communicate the updates via the electronic alert system.
* The service also acknowledged that other consumer care documentation had not been complete including; several restrictive practice forms, the complex health care plan for managing a consumer’s pacemaker and urine test results.

Having considered the evidence in the Site Audit Report (including related points detailed above in Requirement 3(3)(a)) and the Approved Provider’s response, I find that the gaps in documentation identified by the Assessment Team impacted staff knowledge and meant that information about the consumer’s condition, needs and preferences was not always documented and communicated within the organisation, and with others where responsibility for care is shared.

Based on the evidence (summarised above), I find the service Non-compliant with this Requirement.

### 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 7 of the 7 specific requirements have been assessed as Compliant.

Most sampled consumers considered they get the services and supports for daily living that are important for their health and well-being and that enable them to do the things they want to do. Consumers said they have choice in their daily activities and are encouraged to be as independent as possible. Consumers less able to participate in activities are provided more support by staff to do so. For example, consumers with limited mobility who wanted to go walking were assisted by staff.

A review of the lifestyle program and photographs of lifestyle activities showed consumers attended a wide range of activities in the service. The lifestyle assessments in care plans were completed for most of the consumers and staff were aware of specific consumer’s interests. Care plans included information about what is important to consumers and their needs and goals. The lifestyle coordinator maintained detailed lists of activities aligned to the interests and abilities of consumers. Feedback from consumer meetings was used in the development and review of activities across the service and minutes of meetings were reviewed by the team.

The service demonstrated services and supports provided to promote each consumer’s emotional, spiritual and psychological well-being. Consumers sampled reported staff are kind and caring and they are comfortable speaking to them, or management, should the need arise. The care plans for consumers sampled contained information about consumers’ emotional and spiritual well-being and how they can be supported by staff. The service has regular chapel services which most of the consumers attend on a daily basis and there are regular visits from the pastoral carer. Staff explained how they tell if a consumer is feeling sad or low, and said they will refer the consumer to speak with the pastoral carer if additional support is wanted or required.

Consumers were assisted by the service to participate in local community events, maintain contact with family and friends and to do things of interest to them. Care plans identified the people who are important to them both within the service and in the broader community. Staff were able to describe how they supported specific consumers to socialise and maintain personal relationships.

The service demonstrates information about the consumer’s condition, needs and preferences are communicated within the service, and with others where responsibility for care is shared. The care documentation was generally updated although there were some instances where the service did not update or complete care plans when needs and preferences changed. There was evidence of timely and appropriate referrals are made to individuals, other organisations and providers of other care and services. Lifestyle staff work with other organisations and support services to supplement the lifestyle activities offered within the service. The service has policies and procedures in place for making referrals to other individuals and service providers.

Most consumers and their representatives were content with the quality and quantity of meals provided to consumers. Consumers also reported they can access sandwiches and biscuits between meals if they are hungry.

Kitchen staff were provided with a chart indicating any special needs for consumers including a photo of the consumer. The chef maintains folders containing detailed requirements, preferences and dietary needs for all consumers in the service. It is prepared in consultation with consumers and representatives on admission and is regularly reviewed and updated. The kitchen appeared to be clean and tidy and staff were adhering to the service’s food safety plan. These practices include temperature monitoring of refrigerators and meals, ensuring that food products are stored correctly and following cleaning schedules.

The daily menu was displayed on a television screen in each dining area. Dining areas were well presented with tablecloths, flowers, condiments and napkins. Meals appeared well presented and consumers were being assisted with eating their meals if required.

Equipment used to support consumers lifestyle activities was observed to be safe, suitable, clean and well maintained. The service provides a wide range of equipment such as; mobility aids and wheelchairs as well as products such as, games, books, magazines, music, colouring pens and pencils. These appeared clean and well maintained.

Staff reported equipment is cleaned regularly according to a schedule and they will also clean up and sanitise equipment as necessary following use. Maintenance documentation showed there was scheduled and preventive maintenance. There were no outstanding maintenance issues relating to equipment.

## 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 3 of the 3 specific requirements have been assessed as Compliant.

The service demonstrated the environment is welcoming, easy to understand and navigate, and optimises consumer’s independence and enjoyment. Colour cues and signage throughout the service helps provide direction. Other features to support people with cognitive impairment included pictures and numbers on doors, automatic door openers and tags.

Consumers said they felt safe and comfortable in the service and that it felt like home. Consumer’s rooms were personalised with furniture, photographs and bed covers. There were clearly designated areas for activities and quieter areas available for consumers, if they chose. There were multiple garden areas (some shaded) available for consumers and visitors to sit, walk or have meals. Staff were observed welcoming visitors and others to the service. Consumers were offered ample support to mix with visitors and other consumers and they were well monitored by staff.

The service environment appeared safe, clean and well maintained and consumers were able to move freely both indoors and outdoors.

Consumers’ rooms and common areas were clean and well maintained. Consumers described how they are supported to move around the service and gardens as they wish. Gardens were well maintained with shaded areas and level paths through the courtyard gardens.

Staff described how they monitor the safety and comfort of the environment and how they report any safety issues for maintenance. Two full time staff continuously monitor the cleanliness and safety of the service environment according to a schedule and promptly respond to any feedback from consumers and other staff about any issues. Monthly audits are conducted, and additional training provided as necessary. The maintenance log evidenced regular maintenance of the service environment.

Consumers have access to a range of equipment including; walkers, wheelchairs and comfort chairs. Bathrooms contain equipment to support personal care. There were a range of comfort chairs and wheelchairs to support those consumers no longer able to ambulate. Lifting and other equipment was available if needed, and these were cleaned and maintained. Call bells and other mobility aids were observed to be in working order and easily accessible near consumer beds.

The service has a maintenance coordinator and system for scheduled and day to day corrective maintenance. Documentation indicates routine maintenance occurs on time and faulty equipment is identified and responded to promptly. Staff were aware of the maintenance logbook and said they used it as required. They also said that corrective actions were promptly addressed.

## 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 4 of the 4 specific requirements have been assessed as Compliant.

Consumers and representatives felt encouraged and supported to give feedback and make complaints, and that appropriate action was taken. They could explain the internal and external feedback and complaints mechanisms available to them, and said that when raising an issue, management acknowledges their complaint, promptly addresses the issue and resolves it to their satisfaction.

Consumers and their representatives were aware of other avenues for raising a complaint such as; the Aged Care Quality and Safety Commission (the Commission) or through an advocate, such as their family, friends or an advocacy service. They were comfortable raising concerns with management and staff in the first instance and would escalate their complaint accordingly if it was not resolved to their satisfaction.

Most consumers or their representatives said they felt confident that the feedback they provide is considered by the service, and suggestions are implemented as far as reasonably practicable. Consumer and representatives confirmed that positive changes have directly followed feedback they provided.

The service has a documented complaints, grievance and feedback policy that guides staff in the management of feedback, complaints and compliments. The consumer service guide, information handbook and agreement, and quarterly organisational newsletter outline the internal and external complaints avenues available to them. Staff were able to describe how they assist consumers who have a cognitive impairment or difficulty communicating to raise a complaint or provide feedback.

Feedback forms and locked lodgement boxes are available in communal areas of the service. Consumers can make a complaint or give feedback at the monthly consumer meetings, focus groups and during informal and formal discussions with staff and management. Satisfaction surveys are conducted monthly.

The service was able to demonstrate that appropriate and timely action is taken in response to complaints, and an open disclosure process is applied when things go wrong. Staff had received training on open disclosure and demonstrated a common understanding of the principles of open disclosure, including providing an apology to the impacted person/s, and implementing actions to prevent recurrence.

The service was able to demonstrate that feedback and complaints are trended, analysed and used to improve the quality of care and services. Improvement actions taken in response to feedback and complaints are evaluated in consultation with consumers and/or their representatives. The service’s quality improvement system demonstrated that complaints, feedback, suggestions and incidents have been documented, along with planned improvement actions, timeframes and evaluation notes.

## 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 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 5 of the 5 specific requirements have been assessed as Compliant.

Overall, sampled consumers considered they get quality care and services when they need them and from people who are knowledgeable, capable and caring. The service demonstrated the workforce was sufficient and planned to provide quality care and services. Consumers, representatives and staff felt there were sufficient staff to support their care and services and they did not have to wait long to get help. Staff said they were able to consistently meet the care needs of consumers, particularly in relation to the delivery of hygiene care, toileting needs and providing emotional support.

The service was able to demonstrate that the workforce interacts with consumers in a kind and caring manner. Consumers and representatives felt that staff engage with them in a respectful, kind and caring manner, and are gentle when providing care to the consumer. The Assessment Team observed staff and volunteers using consumers’ preferred names and interacting with them in a friendly, kind and respectful manner.

The workforce is recruited, trained, equipped and supported to deliver the outcomes required by the Standards. Most consumers and representatives sampled said staff perform their duties effectively, and they are confident that staff are trained appropriately and are skilled to meet their care needs.

Position descriptions set out the expectations for each role. All recruited staff must meet the minimum qualification and registration requirements for their respective role and ensure that they have current criminal history checks completed. New staff undergo an orientation and onboarding process, which includes a minimum of 3 buddy shifts with experienced staff in their role, site orientation, mandatory training and competencies. There are management systems in place to ensure that staff training is completed as required.

The service was able to demonstrate that the performance of the workforce is regularly assessed, monitored and reviewed. Staff performance is monitored through; observations, competencies (eg manual handling, hand hygiene and medication administration), internal audits, clinical data, and feedback.

The service has probationary and appraisal systems in place. Performance reviews are conducted within 6 months for staff on probation and involve discussions of staff performance and areas that the staff member requires development. The organisation’s human resource team monitors the performance management system and the electronic records. The service has documented policies and procedures that guide the management of the workforce, the selection and recruitment of new staff, orientation and probationary processes, monitoring of staff performance and the performance management of staff when issues are identified in performance.

## 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.*

### 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.*

### 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 5 of the 5 specific requirements have been assessed as Compliant.

Overall, the service demonstrated that the development, delivery and evaluation of care is made in consultation with consumers. Consumers and representatives were confident the service is run well, and they are satisfied with their level of engagement in the development, delivery and evaluation of care and services.

Management were able to describe the ways in which consumers are encouraged to be involved in decisions about the service and the care and services they receive. There are monthly consumer meetings, consumer experience surveys, focus groups, and the feedback and complaints systems. Management advised that invitations to consumers and representatives to attend the monthly Board meeting are rotated across the organisation’s homes.

The service was able to demonstrate the governing body is accountable for the delivery of care and services, and promotes a culture of safe, inclusive and quality driven culture.

The service is governed by a Board who meet monthly to monitor the performance of the service and to ensure the governing body is accountable for the delivery of safe, inclusive and quality care and services. The governing body receives various monthly reports from the service relating to internal audits, consumer/representative and staff feedback and complaints, quality reports, reported hazards and risks, and clinical and incident data analysis. The governing body uses this information to identify the service’s compliance with the Quality Standards, to initiate improvement actions to enhance performance, and to monitor care and service delivery. The organisation’s Board of Clinical Governance and Safety Committee is responsible for monitoring and oversight of risks related to clinical governance, consumer experience, clinical and service care provision and quality improvement. Management was able to provide examples of recent changes driven by the Board as a result of consumer feedback, quality improvements and incidents.

The service was able to demonstrate that there are governance systems in place which guide; information management, continuous improvement, financial governance, workforce arrangements, regulatory and legislative compliance, and feedback and complaints.

The service demonstrated effective risk management systems and practices through a documented risk management framework which included policies addressing how:

* high impact or high prevalence risks are managed.
* the abuse and neglect of consumers is identified and responded to.
* consumers are supported to live the best life they can.
* incidents are prevented, managed and reported.

The organisation demonstrated it has a clinical governance framework that includes policies relating to antimicrobial stewardship, restrictive practices and open disclosure. Staff had been educated about the policies and were able to provide examples of relevance to their work in minimising the need for antibiotics such as hand hygiene, good hydration, proper use of personal protective equipment, and timely identification of infection symptoms.

Staff had received mandatory training and education on open disclosure and minimising the use of restrictive practices.

## 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.

* Requirement 2(3)(d) - Ensure the outcomes of assessment and planning are effectively documented in a care and services plan that is readily available to the consumer, and where care and services are provided.
* Requirement 3(3)(e) - Ensure the 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.