Taralga Retirement Village Hostel

Performance Report

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**Commission ID:** 5110

**Provider name:** Taralga Retirement Village Incorporated

**Site Audit date:** 18 January 2022 to 20 January 2022

**Date of Performance Report:** 3 March 2022

# Performance report prepared by

Tara Wurf, 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) | Non-compliant |
| Requirement 2(3)(b) | Compliant |
| Requirement 2(3)(c) | Compliant |
| Requirement 2(3)(d) | Compliant |
| Requirement 2(3)(e) | Non-compliant |
| **Standard 3 Personal care and clinical care** | **Non-compliant** |
| Requirement 3(3)(a) | Non-compliant |
| Requirement 3(3)(b) | Non-compliant |
| Requirement 3(3)(c) | Compliant |
| Requirement 3(3)(d) | Compliant |
| Requirement 3(3)(e) | Compliant |
| Requirement 3(3)(f) | Compliant |
| Requirement 3(3)(g) | Non-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** | **Non-compliant** |
| Requirement 6(3)(a) | Compliant |
| Requirement 6(3)(b) | Compliant |
| Requirement 6(3)(c) | Non-compliant |
| Requirement 6(3)(d) | Non-compliant |
| **Standard 7 Human resources** | **Non-compliant** |
| Requirement 7(3)(a) | Compliant |
| Requirement 7(3)(b) | Compliant |
| Requirement 7(3)(c) | Compliant |
| Requirement 7(3)(d) | Non-compliant |
| Requirement 7(3)(e) | Non-compliant |
| **Standard 8 Organisational governance** | **Non-compliant** |
| Requirement 8(3)(a) | Compliant |
| Requirement 8(3)(b) | Non-compliant |
| Requirement 8(3)(c) | Non-compliant |
| Requirement 8(3)(d) | Non-compliant |
| Requirement 8(3)(e) | Non-compliant |

# Detailed assessment

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

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

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

* the Assessment Team’s report for the Site Audit; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others;
* the provider’s response to the Site Audit report received 18 February 2022; and
* other information and intelligence about the service held by the Commission.

# 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

Consumers and representatives said staff treat them with dignity and respect and value their culture and diversity. They described how staff provide care and services that are safe for them. Consumers and representatives said the service provides them with information that enables them to make informed choices about their care and services and live the life they choose.

Consumers reported they are encouraged to do things for themselves, that staff know what is important to them and their personal privacy is respected. Consumers and representatives gave examples of where consumers have chosen to take risks and have been supported by the service.

Staff demonstrated respect towards consumers and had an understanding of consumers’ personal circumstances and life journeys. Staff were familiar with consumers’ backgrounds and culture and described how these influence the delivery of care and services. Staff also described ways they enable and support consumers’ lifestyle choices and preferences on a day to day basis. Staff said if they witnessed a consumer being treated inappropriately they would immediately report the issue to management.

Care documentation included information about consumers’ background, identity and cultural preferences and the language used in care planning documents was respectful. Consumers’ documentation contained evidence of consultation with consumers and their representatives, and where privacy and confidentiality processes were adhered to.

The Assessment Team observed staff greeting consumers with familiarity and interacting with consumers in a dignified and respectful manner.

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

## Assessment of Standard 1 Requirements

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

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

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

*Care and services are culturally safe.*

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

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

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

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

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

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

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

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

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

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

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 2

Consumers and representatives were satisfied with their involvement in assessment and care planning processes and reported that they are kept informed of any changes. Consumers said they can access a copy of their care plan and reported they are involved in care planning and assessment, as are others who are important to them and relevant health professionals.

Consumers’ care planning documents included advance care planning and end of life planning and detailed an ongoing partnership with the consumer and others in assessment and planning of their care and services. There was evidence of input from medical officers, pharmacists and allied health professionals. Care documentation (including care plans and progress notes) was available and easily accessible to staff and others involved in the care of consumers.

Registered staff advised consumers are assessed upon entry to the service and where care needs change. Staff described what was important to the consumers in terms of how their personal and clinical care was delivered. Staff demonstrated an understanding of strategies to manage risks for individual consumers.

However, the service’s assessment and planning processes have not consistently considered risks to the consumer or been completed for new consumers to the service.

The service was also not regularly reviewing consumers’ care and services and updating care plans to reflect changes to consumers’ care needs following deterioration and/or the outcome of reviews by other health professionals.

The organisation did not have policies and procedures relevant to this Quality Standard to guide staff practice that were current or tailored to the service.

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

## Assessment of Standard 2 Requirements

### Requirement 2(3)(a) Non-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’s assessment and planning processes have not consistently considered risks to the consumer or been completed for new consumers to the service.

While staff identified the service has a procedure for new consumers entering the service, this procedure had not been followed for a recent new consumer.

Risk assessments are not routinely completed for consumers subject to restrictive practices.

Falls risk assessments have not been completed for a consumer who experienced multiple falls over a four month period that resulted in injury (including a fractured neck that required hospitalisation). While some falls prevention strategies were put in place following fall incidents, the service failed to complete a documented falls risk assessment for this consumer who continued to fall.

Risk assessments have not been completed for two consumers who wear call bell alerts devices around their neck. One consumer experienced an incident where the device became tightly twisted around their neck and the other consumer’s device was observed to be on a metal chain that did not provide a safety release feature for when pressure is applied to the chain.

A consumer who chooses to undertake an activity that poses risk to them has not had a risk assessment completed in relation to that activity, including after an incident where the consumer sustained injury.

Registered staff are responsible for assessment and care planning processes. Staff reported they receive information about consumer’s needs and risks during shift handover and discussions with registered staff, and in consumer’s care documentation.

Although the service had documented policies provided by a national peak aged care industry body, these were generic and not current or tailored to the service. Management and clinical staff were unaware if the service had policies and procedures relating to assessment and care planning and provided different advice about these processes.

Staff did not have a common understanding about what risk assessment documentation they should use. Risk assessments for restrictive practice were completed on workplace health and safety (WHS) safe environmental forms which were suitable to assess the risks associated with restrictive practices.

The approved provider’s response to the Site Audit Report identified actions taken or planned to address the areas of deficiency relating to assessment and planning. Risks assessments and care planning were completed for those consumers named in the Site Audit Report. Other improvement actions included:

* Reviewing and updating policies and procedures.
* Registered staff to utilise a 28 day planner to ensure assessments are completed for new consumers.
* Development of a risk register to identify consumers at risk.
* Staff education on a range of topics including restrictive practices, falls management, incident management and skin assessments.

While the approved provider has taken or proposed actions to address deficiencies identified, at the time of the site visit, the service’s assessment and planning processes were not consistently being completed or considering risks to consumers. Therefore, I find this requirement non-compliant.

### 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.*

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

*The organisation demonstrates that assessment and planning:*

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

### Requirement 2(3)(d) 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.*

### Requirement 2(3)(e) Non-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.*

Consumers’ care and services have not been reviewed regularly for effectiveness, and when circumstances change or incidents occur.

A consumer that experienced significant weight loss over a six month period was reviewed by a dietician and had dietary changes implemented. However, additional weight loss occurred which did not trigger reassessment of the consumer and the effectiveness of the strategies in place.

Care plans were not routinely updated to reflect changes to consumers’ care needs following deterioration and/or review by other health professionals. For example:

* A consumer’s care plan did not accurately reflect their mobility needs and was not updated following a deterioration and physiotherapist review that identified the consumer could not longer use a wheelie walker and was a sling hoist for all transfers.
* Another consumer’s behaviour support plan was not reviewed or updated following an assessment by Dementia Services Australia (DSA). The consumer continued to experience behavioural incidents.
* Another consumer’s care plan was not updated to reflect the consumer had a stage 1 pressure area and the strategies that were in place to manage the pressure injury.

Management were unaware whether the service had policies and procedures relating to assessment and care planning to guide staff practice. Management, registered staff and care staff did not have a shared understanding of the service’s processes or schedule for reviewing consumers’ care and services. Care staff said they were unaware if any review processes had been occurring.

The approved provider’s response to the Site Audit Report identified actions taken and planned to address deficiencies. Consumers named in the site audit report have been reviewed and action taken where appropriate. Other improvement actions include updating policies and procedures, establishing schedules for three-monthly care plan reviews and regular case conferences, and monthly reviews of consumer’s weights.

While the approved provider has commenced action to address the identified deficiencies, at the time of the site audit, the service was not regularly reviewing consumers’ care and services and updating care plans. Therefore, I find this requirement non-compliant.

# STANDARD 3 NON-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

Consumers and representatives were satisfied with the care and service they receive and considered their needs and preferences are met. They felt engaged in decisions about their care. Consumers/representatives were satisfied timely and appropriate referrals occur when needed and they have access to relevant health professionals such as allied health professionals, medical specialists and specialist services.

Staff described the mechanisms they use to share and receive information about consumers, including via the electronic care system and handover. The service has an electronic care management system that stores consumers’ care documentation, which is accessible to staff, medical officers and other health professionals and reflected the input from these health professionals. Progress notes demonstrate the consumer’s representative and medical officer are informed when a consumer experiences a clinical incident, a change in condition or when transferred to or return from hospital.

Consumers were referred to specialist services including allied health services in a timely manner. Care documentation demonstrated deterioration or changes in the consumer’s health care needs were generally responded to in a timely manner.

Care planning documentation was individualised and included end of life planning. Consumers and representatives expressed confidence in the service’s ability to support their end of life care. Staff described their role in end of life care and practical ways they support consumers to be comfortable. The service receives support from the palliative care nurse at the local hospital and medical officers.

However, the service was unable to demonstrate clinical care delivery was safe and effective in relation to the management of restrictive practices, continence and oxygen. The service’s management of pain and wounds did not reflect best practice.

Consumers with high-impact or high-prevalence risks related to their care were not effectively managed, particularly in relation to management of nutrition (weight loss) and falls.

The service’s processes in place to minimise infection-related risks were ineffective.

The organisation did not have policies and procedures relevant to this Quality Standard to guide staff practice that were current or tailored to the service.

The Quality Standard is assessed as non-compliant] as three of the seven specific requirements have been assessed as non-compliant.

### Assessment of Standard 3 Requirements

### Requirement 3(3)(a) Non-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.*

Consumers and representatives were satisfied with the care and service they receive and considered their needs and preferences are met. However, the service was unable to demonstrate clinical care delivery was safe and effective in relation to the management of restrictive practices, continence and oxygen. The service’s management of pain and wounds did not reflect best practice.

Management and clinical staff were unable to identify the types of restrictive practices used at the service or which consumers were subject to restrictive practice. The service did not have a process or system to identify and track use of restrictive practices. Authorisations for the use of multiple restrictive practices and informed consent from a consumer/representative had not been completed. Management and clinical staff were not aware that some of these restrictive practices were in place for the consumer.

Care planning documentation for one consumer was incomplete and did not identify their continence and bowel management care needs. Progress notes identified an incident where the consumer’s continence aid was not changed for 3 days, following which the consumer’s groin and thigh area became red and inflamed. No response or follow up to this incident was taken.

Another consumer was observed by the Assessment Team to have an oxygen concentrator in their room which the consumer advised they use as required. The consumer was unaware whether staff clean and maintain the equipment. The consumer’s care planning documentation did not identify the consumer required oxygen or provide any instruction to staff about the oxygen concentrator. Clinical staff were unaware the consumer required oxygen.

Registered staff reported they know the care they provide is safe and effective by what they observe and the training they receive. However, the service is not providing relevant training (this is addressed under requirement 7(3)(d)).

Consumers’ wound care documentation demonstrated wounds are documented, attended to as scheduled, reviewed regularly by registered staff and are healing. However, wounds are not being photographed or measured in line with best practice.

Consumers’ pain management documentation reflected pain was being managed effectively. However, alternative strategies were not used prior to the administration of analgesia, and effectiveness of the analgesia were not consistently documented.

Although the service has documented policies provided by a national peak industry body for aged care services, these were generic, and not current or tailored to the service

The approved provider’s response to the Site Audit Report evidenced that the service is taking action to review consumers named in the Site Audit Report. Other improvement actions include:

* Reviewing and updating policies and procedures.
* Staff education on updated policies and procedures and various topics such as incident management, assessment and care planning, restrictive practices, pain management and skin care.
* Implementing a new restrictive practice assessment forms.
* Clinical monitoring of wound care documentation.

While the approved provider has commenced action to address the identified deficiencies, at the time of the site audit, the service was not consistently providing care that was safe and effective in relation to the management of restrictive practices, continence and oxygen, and best practice in relation to wound and pain management.Therefore, this requirement is non-compliant.

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

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

Consumers’ care documentation generally identified high impact or high prevalence risks for consumers, and management and staff identified the highest clinical risks for individual consumers and strategies in place to manage the risks. However, the service was not effectively managing the risks to consumers in the areas of nutrition (weight loss), falls management and restrictive practices.

A review of care planning documentation identified that staff were not effectively managing significant weight loss for two named consumers. While the consumers were reviewed by a dietician and dietary changes implemented, ongoing weight loss did not trigger reassessment or review of the consumer and the effectiveness of the strategies in place. Refer to requirement 2(3)(e) for further information.

For a consumer identified as a high falls risk and who had experienced multiple falls resulting in injury (including neck fracture), the service failed to complete a falls risk assessment for the consumer and the medical officer’s instruction for post fall observations were not consistently followed. The consumer continued to fall. Clinical staff were not ensuring the consumer was reassessed following falls, including monitoring the effectiveness of strategies to manage and/or to minimise the consumer’s falls risk.

I have also considered information in requirement 3(3)(a) relating to the service’s management of restrictive practices under this requirement.

While the service monitors clinical incident data through monthly audits, the data did not include falls incidents identified by the Assessment Team in consumers’ care documentation.

The service does not have policies or procedures relating to high impact, high prevalence risks to guide staff in the effective management of risks.

The approved provider’s response to the Site Audit Report evidenced that the service is taking action to review consumers named in the Site Audit Report. The approved provider also evidenced an instance of post fall monitoring for one consumer and another consumer’s representative’s preference for no further interventions in respect of the consumer’s nutrition and hydration. This information did not persuade me. I am of the view that the service’s processes for assessing, monitoring and managing risks related to personal and clinical care were inconsistent and ineffective.

The approved provider also committed to a number of improvement actions, such as:

* Reviewing and updating policies and procedures.
* Staff education on various topics such as, assessment and care planning, restrictive practices, and falls management.
* Monitoring consumers’ weights.

While the approved provider has commenced action to address the identified deficiencies, at the time of the site audit, the service was not effectively managing the risks to consumers in the areas of nutrition (weight loss), falls management and restrictive practices.Therefore, this requirement is non-compliant.

### 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.*

Care documentation demonstrated deterioration or changes in consumers’ health care needs were generally responded to in a timely manner. I have considered information about the ongoing management and deterioration of some consumers named in this requirement under requirements 2(3)(e) and 3(3)(b).

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

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

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

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

### Requirement 3(3)(g) Non-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.*

The service’s processes in place to minimise infection-related risks, including processes to manage a potential COVID-19 outbreak were ineffective.

Consumers and representatives described actions taken by the service to manage a potential COVID-19 outbreak. Staff described strategies to minimise the need for or use of antibiotics, and how infection related risks are minimised at the service. Staff said they had completed online education related to infection control related topics, however, the service could not demonstrate records to support this information (this is addressed under requirement 7(3)(d)).

However:

* The service’s paper-based system of recording infections was not current.
* Management advised the service does not have an infection prevention control (IPC) lead.
* The Assessment Team was not appropriately screened upon entry by the service on day 2 and 3 of the site audit during the service’s lockdown.
* Staff were observed not wearing their masks correctly while attending to consumers.
* The service did not have documented procedures to guide staff in relation to antimicrobial stewardship.

The approved provider’s response to the Site Audit Report identified actions taken or planned to address the deficiencies, which included:

* Review of the service’s infection control manual, including for COVID-19 outbreak management.
* Recruit and appoint a permanent IPC lead.
* Update staff on current COVID-19 health directives.

While the approved provider has commenced action to address the identified deficiencies, at the time of the site audit, the service did not have effective process in place to minimise infection-related risks. Therefore, this requirement is non-compliant.

# 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

Consumers were satisfied with the services and supports for daily living that they received. They said they are supported to undertake their preferred lifestyle activities and that they can maintain relationships with people who are important to them. Consumers provided examples of the activities they enjoy both inside and outside the service including meeting with friends, playing music, exercise classes, games and crafts. Consumers and representatives said staff are kind and caring and are sensitive in their approach.

Consumers and representatives were satisfied with the meals provided and said they were able to provide feedback and have input into the menu. They spoke positively about the variety, quantity and quality of the food and said staff knew their preferences.

Care planning documentation included information about consumers’ lifestyle preferences, significant relationships and details about their life history. Strategies to support consumers’ emotional and spiritual well-being were documented and available to guide staff in the way they delivered care and services.

Care planning documentation provided evidence that referrals are made to allied health specialists and other providers of care in order to meet consumers’ individualised needs. This included referrals to the National Disability Insurance Scheme, dementia advisory services and psychology services.

Lifestyle staff described the assessment and care planning process and how they liaise with the consumer to build a picture of the consumer’s life including their previous work life, interests and background. Staff were familiar with the consumers and were able to explain how they support consumers’ spiritual needs and how they assist the consumer when there is a change in their demeanour.

Information about consumers is shared, where appropriate, through handover and the electronic care management system. Dietary information is communicated to the hospitality staff including when changes have been made to the consumer’s diet.

Catering staff were familiar with consumers’ dietary preferences. Staff said they had completed safe food handling training and that audits were conducted within the kitchen to ensure compliance with food safety obligations.

Staff said they had access to the equipment they required to meet consumers’ needs and consumers confirmed that equipment such as mobility aids, shower chairs and manual handling equipment was available to them.

The Assessment Team observed activity schedules displayed in several locations throughout the service. The service was experiencing COVID-19 restrictions during the site audit and staff were observed engaging with consumers in one to one activities and those consumers who were restricted to their rooms were participating in various activities including reading, knitting, jigsaws and watching movies.

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

## 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

Consumers and representatives said consumers feel at home within the service and that the service is clean, comfortable and well-maintained.

The Assessment Team observed the service was clean, secure and well-maintained. The service was welcoming and easy to navigate, and consumers were able to move freely through indoor and outdoor areas. Consumers resided in individual rooms that were decorated with personal belongings. Consumers’ rooms had an ensuite and each room also had access to outdoor areas.

Strategies to support the safety of the environment included wide corridors with natural lighting and handrails, fire safety equipment was available and exit signage was illuminated and evident throughout the service. Consumers had call bells within their rooms and some consumers were noted to be wearing call bell pendants.

Management staff said a schedule guides cleaning practices and that cleaning hours have recently been extended to include weekends. A preventative and reactive maintenance program ensures that equipment and the service environment is suitable for consumers’ use.

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

## 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 NON-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

Consumers/representatives reported they are supported and felt safe to give feedback and make complaints and were confident the service would respond to their complaints. Consumers said they mostly speak to staff or management directly. Some consumers were aware of alternate feedback/complaints mechanisms and external advocacy services available to them.

Staff described the service’s feedback and complaints processes and how they support consumers to provide feedback or make a complaint. Some staff could describe advocacy services available to assist consumers. Management advised consumers/representatives are provided with information about how to make a complaint, verbally or in writing.

Information about the service’s complaints process, and advocates and language services are provided in the consumer handbook. Information about advocacy groups, language services and external complaints processes is displayed on noticeboards throughout the service. Records of consumer meetings minutes demonstrated consumers are provided information about the service’s feedback and complaints process and access to external complaints bodies and advocacy groups.

However, while the service had a documented complaint handling policy, it did not include an open disclosure process and the service could not demonstrate staff have received training in complaints processes.

The service was also unable to demonstrate appropriate and timely action was taken in response to complaints, or that feedback and complaints are used effectively to improve quality of care and services.

The Quality Standard is assessed as non-compliant as two of the four specific requirements have been assessed as non-compliant.

## 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) Non-compliant

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

Consumers were generally satisfied with the service’s response to complaints and said staff offer an apology when things go wrong. However, the service was unable to demonstrate an appropriate complaints management system was in place. Appropriate action was not consistently taken in response to complaints and the service did not have an open disclosure process.

While the service had a complaints policy in place, this did not include information about open disclosure. Management were unable to describe the organisation’s complaints process, including an open disclosure process.

The service maintains a feedback and complaints folder. Feedback generally related to minor changes in consumer preferences and compliments about the care. A complaint record in November 2021 about rough handling was incomplete and did not record any action taken in response to the complaint. Management advised they do not keep a record of actions taken in response to complaints.

The approved provider’s response to the Site Audit Report identified the complaint recorded in November 2021 had been actioned and closed in February 2022, the complaints handling policy/procedure had been updated (and included reference to open disclosure) and a compliments and complaints register was in place and recorded outcomes and actions taken.

While the approved provider has undertaken improvement actions related to this requirement, these will require time to embed and demonstrate they are effective and sustainable. Therefore, I find this requirement non-compliant.

### Requirement 6(3)(d) Non-compliant

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

The service has not demonstrated that feedback and complaints were reviewed, informed quality improvement and resulted in improvements in care and service delivery for consumers.

Consumers were unable to provide examples of improvements made as a result of feedback or complaints, however, expressed confidence that management would implement changes if required.

Management advised feedback and complaints are not tracked or trended within the organisation and they were not aware of any trends in complaints information. Management was unable to identify planned or made improvements as a result of complaints or feedback.

Complaints records did not consistently record outcomes of complaints and feedback and the service’s plan for continuous improvement did not reflect the use of feedback or complaints in improving the quality of care and services.

I have also considered information in the Site Audit Report under requirement 6(3)(c), including that the service has not routinely reported complaints, complaints trends or reportable incidents to the organisation’s Board.

The approved provider’s response to the Site Audit Report stated that complaints are tracked, and that food surveys and complaints have resulted in changes to the menu as evidenced in consumer meeting minutes. I am not persuaded by this one example of improvement and have also given weight to the fact that management on the day of the site audit could not identify complaint trends or improvements made as a result of complaints.

The response also identified the service would implement a complaints register and revise policies and procedures to ensure complaints are linked to the quality system and the service’s plan for continuous improvement.

While changes to the service’s menu have been made in response to consumer feedback, the service could not demonstrate a robust system whereby the service actively monitored, reviewed and trended complaints, and used these to inform quality improvement actions. Therefore, I find this requirement non-compliant.

# STANDARD 7 NON-COMPLIANT Human resources

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 7

Consumers and representatives considered that they get quality care and services when they need them and from staff that are kind and caring. They reported there is sufficient staff to meet their needs, and staff know what they are doing and understand their backgrounds and preferences. Consumers were satisfied staff are competent and well trained.

Management demonstrated staffing levels are reviewed and adjusted in line with consumer numbers and needs. Management described significant changes to key personnel at the service during 2021, however identified these positions are now stable. The service utilised agency registered staff on a regular basis.

Staff reported they have enough time to perform their duties and have access to training.

The organisation has documented position descriptions for each role. New staff complete orientation prior to starting. Management described the service’s processes to identify whether staff are competent and capable in their roles, which included observations of staff, feedback from consumers and feedback from supervisors.

The Assessment Team observed staff performing their duties without appearing rushed, responding promptly to call bells and engaging positively with consumers.

However, staff do not receive regular training relevant to their role, including mandatory training, and the service does not have a staff performance framework or processes in place to assess, monitor or review the performance of staff.

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

## 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) Non-compliant

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

While the service has recruitment and selection processes in place and consumers and representatives feel staff are well trained, staff have not received regularly training relevant to their role, including mandatory training. The service does not have processes to identify, monitor or record staff training requirements.

Some staff expressed concern about a lack of training and the majority of staff interviewed were not aware whether they had completed mandatory training relevant to their role.

Staff training records have not been consistently maintained, reviewed or updated, were incomplete, and did not accurately reflect the current staffing cohort.

Management was unable to identify staff training needs, however, described a new staff training matrix that was in development to identify training requirements relevant to roles.

The approved provider’s response to the Site Audit Report provided some evidence of online training (via Altrua) and a session on cultural awareness/SIRs completed by some staff in 2021, however, did not provide evidence of mandatory training or a planned approach to staff training. The approved provider identified actions taken and planned to address the identified deficiencies, which included:

* Review of mandatory training gaps for staff and schedule to complete training.
* A formal orientation program and schedule.
* An annual education plan for mandatory training and special topics to address gaps in staff education and knowledge.
* A new process for recording staff training.

While the approved provider has commenced action to address the identified deficiencies, at the time of the site audit, the service did not have effective processes to identify, monitor or record staff training and staff had not received regularly training relevant to their role, including mandatory training. Therefore, I find this requirement non-compliant.

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

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

The service did not have a staff performance framework or procedures in place and was not assessing, monitoring or reviewing staff performance. Management advised that the Human Resource Management policy was under review.

The service did not have documented records of staff performance appraisal completed. Most staff said they had not had a recent performance appraisal and could not recall when they last had one.

Management advised staff performance is monitored through observations, consumer and staff feedback and discussions with staff, however, documented evidence to support this was not provided. Management could not articulate how consumer feedback is incorporated into the monitoring and review of staff performance.

The approved provider’s response to the Site Audit Report identified the service planned to develop a staff performance register and schedule to track and record staff performance appraisals.

At the time of the site audit, the service did not have effective systems and process in place to assess, monitor and review staff performance. Therefore, I find this requirement non-compliant.

# STANDARD 8 NON-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

Consumers and representatives sampled said they believe the service is well run and reported satisfaction with the level of engagement they have with staff and management. They reported that they have opportunities to provide feedback and be involved in the development of care and services through methods such as consumer/representative meetings, direct discussion with staff and management and completing surveys and feedback forms.

Management advised consumers/representatives are actively engaged through participation in consumer meetings and input into the activities program.

Consumer meeting minutes demonstrated that consumers have participated in discussions concerning menu development and evaluation, lifestyle activities, garden development plans and maintenance issues.

However, the organisation was unable to demonstrate:

* effective organisation-wide governance systems in place in relation to information management, continuous improvement, workforce governance, regulatory compliance, and feedback and complaints;
* effective risk management systems and practices were place, specifically in relation to the management of high impact or high prevalence risks associated with the care of each consumer, and the management and prevention of incidents. This has resulted from ineffective monitoring processes at a service and organisational level;
* effective clinical governance framework or current policies regarding antimicrobial stewardship, minimising the use of restraint and open disclosure are in place; and
* the organisation’s governing body promoted and was accountable for delivery of safe, inclusive and quality care.

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

## 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) Non-compliant

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

The organisation’s governing body was unable to demonstrate they promote a culture of safe, inclusive, quality care and services or are accountable for their delivery.

The organisation has a strategic plan which was developed in 2019 but no longer reflected the operational environment of the service.

The President of the organisation’s governing body advised that the Board became concerned in July 2021 about the operation of the service and the lack of information provided by service management to the Board. An external consultant was engaged and conducted a review of the service’s operations in November 2021 to identify gaps in operational and governance arrangements.

While the Board was able to demonstrate that some actions have been taken in response to the consultant’s review, there has been insufficient time to demonstrate these actions are effective and sustainable. Other improvement actions identified by the consultant have not been implemented. Furthermore, there continues to be significant gaps in the organisation’s ability to demonstrate accountability for service delivery based on the widespread non-compliance identified at the site audit (non-compliance in 13 requirements across six of the Quality Standards).

While the service has a revised template to report to the Board about various matters, the service was unable to demonstrate that such reporting was currently occurring or that sufficient information was provided to the Board to allow for effective oversight of the service.

Although the service utilises polices provided by a national peak aged care industry body, these are out of date, not tailored to the service and did not reflect changes in the service’s legislated responsibilities (such as SIRS and restrictive practices). Management was unable to advise the process or who in the organisation was responsible for the review and updating of policies and procedures.

The Board was scheduled to receive training on the Quality Standards from 1 February 2022.

The approved provider’s response to the site audit evidenced board reports for January and February 2022 that included reporting of various matters including, but not limited to, data on clinical indicators and risks, SIRS incidents, infection control, complaints and staffing.

The approved provider also committed to a number of improvement actions, such as:

* Review the organisation’s management and clinical governance framework.
* Engaged an external consultant to review and revise the service’s strategic plan.
* Reviewed and revised policies and procedures and provide staff education on these.
* Established a process for policy and procedures to be updated following legislative changes and reviewed annually.
* Review of the roles and responsibilities for monitoring processes for Board and staff.

While the approved provider has taken and proposed a range of improvement actions, these will require time to embed and demonstrate they are effective and sustainable. Therefore, I find this requirement non-compliant.

### Requirement 8(3)(c) Non-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 organisation generally had effective financial governance systems in place however, organisational governance systems that related to the management of information, continuous improvement, workforce governance, regulatory compliance and feedback and complaints were ineffective.

Staff said they can generally access information they need relevant to their roles through the service’s electronic care management system and via staff shift handover.

However, service’s suite of policies and procedures were generic, and not current or tailored to the service. Policies had not been reviewed or updated, including to reflect legislative changes. For example, the service’s records management policy and risk management procedure had not been updated and contained out of date information relating to incident reporting, restrictive practices, and use of an incident management system (IMS). The organisation does not have a policy that references or provides guidance in relation to the serious incident report scheme (SIRS).

The service did not have documented evidence support that regular staff meetings occur. Records of staff meeting minutes were not available after June 2021.

Information under requirement 2(3)(e) demonstrated the service’s process to ensure care plan information was current were not effective. Information under Standard 6 and 7 demonstrated the service does not have effective information management systems and processes for monitoring, tracking and recording staff training and performance management and complaints.

While the service had a plan for continuous improvement in place (established in December 2021) that recorded improvement actions (some of which had been completed), the service was unable to demonstrate robust continuous quality improvement systems or a culture of continuous improvement. There was no evidence of a PCI prior to December 2021 and management advised that prior to November 2021, the service did not consistently identify opportunities for improvement or document actions taken to improve performance. Information under requirement 6(3)(d) demonstrated the service does not use complaints and feedback to inform the service’s plan for continuous improvement. The service was unable to demonstrate that its governing Board effectively monitored and ensured that the Quality Standards were being met, as considered under requirement 8(3)(b).

The organisation was unable to demonstrate effective workforce governance processes that ensured staff received training relevant to their role and that the performance of staff was assessed, monitored and reviewed. Refer to Requirement 7(3)(d) and 7(3)(e) for further information.

Management advised that they monitor changes to legislative requirements through correspondence received from a national peak industry body for aged care services, and external agencies and regulatory bodies. Changes to legislative requirements are disseminated to staff through staff meetings, email correspondence, staff education and training sessions. However, the service was unable to demonstrate these monitoring processes are effectively implemented or documented, including in organisational policies and procedures. For example, the service did not have policies or procedures regarding the reporting of incidents under the serious incident reporting scheme (SIRS) and the restraint management policy did not reflect recent regulatory changes regarding the management of restrictive practices.

The service’s complaints management system was ineffective, including in ensuring appropriate action was taken in response to complaints and feedback and complaints were used to improve the quality of care and services. The service was unable to demonstrate that the organisation’s Board was aware of complaints information, trends, and any improvements made. Refer to requirements 6(3)(c) and 6(3)(d) for further information.

The approved provider’s response to the Site Audit Report demonstrated that actions are being taken to address the deficiencies identified in this requirement. Actions included review of the organisation’s information systems, review of monitoring processes, training for staff, revised policies and procedures, and an updated system to report and record incidents.

I have also considered the improvement actions identified relevant to other requirements under this requirement. However, at the time of the site audit, management systems and processes were not effective relating to information management, continuous improvement, workforce governance, regulatory compliance and feedback and complaints. Therefore, I find this requirement non-compliant.

### Requirement 8(3)(d) Non-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.*

The organisation was unable to provide a documented risk management framework, plan, or current policies describing how:

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

While the service had a risk management procedure authorised in November 2019, the service was unable to demonstrate it had effective risk management systems and practices.

The service was not effectively managing the risks to consumers in the areas of nutrition (weight loss), falls management and restrictive practices.

The service did not have a documented incident management system or procedures and did not consistently record dates, times and details of incidents. Incident reporting has not been used to identify risks to consumers or drive continuous improvement.

Staff advised they were aware of where to access the service’s policies but stated they had not accessed them to guide their practice. Although staff could describe processes for reporting abuse and neglect of consumers, staff did not demonstrate a shared understanding of the incident management system or SIRS. The service was unable to provide a documented policy or procedure or staff training records in relation to SIRS.

The approved provider’s response to the Site Audit Report demonstrated that actions are being taken to address the deficiencies identified in this requirement. Actions included:

* Review the organisation’s risk management framework.
* Use of the Commission’s Effective Incident Management System as a framework to manage incidents.
* Update the organisation’s system to report and record incidents.
* Revise policies and procedures and train staff.

I have also considered the improvement actions identified relevant to other requirements under this requirement. However, at the time of the site audit, the service did not have an effective risk management system. Therefore, I find this requirement non-compliant.

### Requirement 8(3)(e) Non-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.*

The organisation did not demonstrate an effective clinical governance framework that supported clinical care practice within the service.

The organisation was unable to provide to provide a policy relating to antimicrobial stewardship, minimising the use of restraint or open disclosure. Management and registered staff did not have a contemporary or shared understanding of these. Refer to requirements 3(3)(a), 3(3)(g) and 6(3)c) for further information.

The service’s clinical governance framework dated 2020, was unauthorised by the Board, and was a generic document provided by an external provider. While the service had identified the framework required review, this had not been completed.

Management advised the service conducts internal audits and mandatory quality indicator reporting and these reports are provided to the governing Board and inform service improvements. However, documentation evidencing reporting as well as resulting actions, evaluation or monitoring was mainly absent for 2021.

Staff could not describe how they utilise the service’s policies in relation to clinical care or the relevance to their work. While some staff said they had received training on policies, training records were not available to support this.

The approved provider’s response to the Site Audit Report identified actions taken or planned to address the deficiencies, including:

* Review the management and clinical governance framework.
* Implement policies and procedures on antimicrobial stewardship, restraint minimisation, open disclosure, workforce governance and risk management.
* Distribute information to consumers and train staff on SIRS, restrictive practices, open disclosure and complaints.

While the approved provider has commenced action to address the identified deficiencies, at the time of the site audit, the service’s clinical governance systems were ineffective. Therefore, this requirement is non-compliant.

# 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)(a) – Assessment and planning processes consider risks to the consumer and are completed for new consumers to the service.
* Requirement 2(3)(e) – Consumers’ care and services are regularly reviewed and care plans updated to reflect changes or reviews by other health professionals.
* Requirement 3(3)(a) – Consumers receive safe and effective personal and/or clinical care, including in relation to the management of restrictive practices, continence and oxygen. Clinical care is best practice in relation to pain and wound management.
* Requirement 3(3)(b) – High impact and high prevalence risks associated with the care of each consumer are managed, including in relation to nutrition and hydration, falls management and restrictive practices.
* Requirement 3(3)(g) – Infection control-related risks are minimised.
* Requirement 6(3)(c) – Appropriate action in is taken in response to consumer complaints, and an open disclosure process is used when things go wrong.
* Requirement 6(3)(d) – Feedback and complaints are reviewed, trended and used to improve the quality of care and services.
* Requirement 7(3)(d) – The workforce is trained and supported to deliver care and services relevant to their role.
* Requirement 7(3)(e) – The performance of each member of the workforce is assessed, monitored and reviewed.
* Requirement 8(3)(b) – The organisation’s governing body promotes a culture of safe, inclusive, quality care and services and is accountable for their delivery.
* Requirement 8(3)(c) – Effective organisation wide governance system are in place relating to information management, continuous improvement, workforce governance, regulatory compliance and feedback and complaints improvement.
* Requirement 8(3)(d) – A documented risk management framework and relevant policies are in place.
* Requirement 8(3)(e) – An effective clinical governance framework is in place. The organisation has policies/procedures relevant to antimicrobial stewardship, minimising the use of restraint or open disclosure.